

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |                                      |  |  |  |   |  |
|--|--|---|--|--|--|--------------------------------------|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |  |  |                                      |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |                                      |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b><br>c. LENGTH OF STAY IN 1b<br><b>6 hours</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Gaithersburg</b><br>d. STREET ADDRESS<br><b>Rtl</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Seymour Tillie Addison</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>6</b> Year <b>1961</b>   |  |                                      |  |  |  |   |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>C</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>4/4/ 1879</b> |  | 9. AGE (In years last birthday)<br><b>82</b> yrs.                                  |  | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |                                      |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Montgomery, Maryland</b> |  |   |  |
| 13. FATHER'S NAME<br><b>David Addison</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Jane Prather</b>  |  |                                      |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.  |  |                                      |  | 17. INFORMANT<br>Address   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure.</b><br><b>450.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized Arteriosclerosis.</b><br>DUE TO (c) <b>Arteriosclerotic Gangrene, Rt. Foot.</b> |  |   |  |  |  |                                      |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |                                      |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                      |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b></b> e.m. <b></b> p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)                  |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August 9-11, 1961</b> to <b>Sept 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept 7, 1961</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.  |  |   |  |  |  |                                      |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Luciano I. Leal</b>   |  |   |  | 22b. DATE SIGNED   |  |                                      |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Luciano I. Leal</b>                             |  |   |  |
| 22d. ADDRESS<br><b>Gaithersburg Md.</b>  |  |   |  | 22e. REC'D BY REGISTRAR<br>DATE <b>SEP 13 '61</b>  |  |                                      |  | 22f. REGISTRAR'S SIGNATURE<br><b>Arthur J. [Signature]</b>                         |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 23b. DATE THEREOF<br><b>9/10/61</b>  |  |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brooke Grove.</b>                         |  |   |  |
| 23d. LOCATION (City, town or county)<br><b>Laytonsville, Md.</b>   |  |   |  | 23e. REC'D BY REGISTRAR<br>DATE <b>SEP 13 '61</b>  |  |                                      |  | 23f. REGISTRAR'S SIGNATURE<br><b>Arthur J. [Signature]</b>                         |  |   |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert F. Sanodan</b> ADDRESS<br><b>Rockville, Md.</b>   |  |   |  |  |  |                                      |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10314

CERTIFICATE OF DEATH

Item 19 Film 0295 9/25/61 ink

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|--|--|---|--|---|--|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda  |  | c. LENGTH OF STAY IN 1b<br>26 days  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Maryland |  | b. COUNTY<br>Washington  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hagerstown |  | d. STREET ADDRESS<br>122 Hump Road   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>Karen Lynn Andrews  |  | 4. DATE OF DEATH<br>September 18 1961   |  | 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>February 23, 1957  |  | 9. AGE (In years last birthday)<br>4 yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Child   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>Harry L. Andrews  |  | 14. MOTHER'S MAIDEN NAME<br>Shirley Blank  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br>No |  | 16. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMATION<br>The Medical Record<br>The Clinical Center, Bethesda 14, Maryland |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e)<br>204-3<br>DUE TO<br>Gram negative septicemia<br>DUE TO<br>acute lymphocytic leukemia<br>DUE TO<br>20 mos.               |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |  |  |  |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from August 23, 1961 to September 18, 1961 that (I) (we) last saw the deceased alive on September 18, 1961, and that death occurred at 12:55 AM from the causes and on the date stated above. |  | 22a. SIGNATURE<br>Thorne S. Winter, III<br>M.D.<br>22c. PHYSICIAN'S NAME (Type)<br>THORNE S. WINTER, III, M.D.  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/><br>22d. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda 14, Md. |  | 22b. DATE SIGNED<br>9/18/61   |  |  |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>9/20/1961  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Lawn Memorial Gar.  |  | 23d. LOCATION (City, town or county)<br>Hagerstown  |  | (State)<br>Maryland  |  |  |  |  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Suter - Rouzer Funeral Home<br>Hagerstown, Md.   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>SEP 21 '61   |  | 25b. REGISTRAR'S SIGNATURE<br>Arthur L. Thoma   |  |   |  |  |  |  |  |  |  |   |  |   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10315

## CERTIFICATE OF DEATH

Reg. Dist. No. 10310

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>  |  | c. LENGTH OF STAY IN 1b <u>3 months</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Broke Grove Foundation</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Charles Henry ASHTON</u>   |  | 4. DATE OF DEATH Month Day Year<br><u>Sept 21 1961</u>   |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-16-74</u>  |
| 9. AGE (In years last birthday) <u>87</u> yrs.   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   | 11. IF UNDER 24 HRS. Months Days Hours Min.                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit Bus Company</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>Charles Ashton</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Ida Welch</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----  |  | 16. SOCIAL SECURITY NO. <u>578-10-8114</u>   |  |
| 17. INFORMANT <u>Mrs. Hazel Welch</u> Address <u>5511 Muncaster Mill Road Rockville, Maryland</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u><br><u>yes.</u> |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month. Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>Sept 20</u> , 19 <u>61</u> , to <u>Sept 21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>61</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>OLNEY, Md.</u> DATE SIGNED <u>9/21/61</u>   |  |  |  |
| ACTUAL SIGNATURE <u>Richard A. Yates MD.</u>   |  | PHYSICIAN'S NAME (Type) <u>Richard A. Yates</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>Sept. 23, 1961</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>King George County, Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>   |  | 24a. REC'D BY REGISTRAR <u>SEP 28 61</u> DATE  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>                           |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10316

## CERTIFICATE OF DEATH

10311

|  |                              |   |                                   |  |  |   |  |
|--|------------------------------|---|-----------------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                              |   |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |                              | c. LENGTH OF STAY IN 1b<br><u>28 hrs</u>  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>                                 |  | d. STREET ADDRESS<br><u>12308 KANSAS Avenue</u>                         |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban</u>  |                              |   |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>SUSIE</u> Middle <u>ASKINS</u> Last <u>ASKINS</u>  |                              |   |                                   | 4. DATE OF DEATH<br>Month <u>SEPT</u> Day <u>10</u> Year <u>1961</u>   |  |   |  |
| 5. SEX<br><u>7</u>   | 6. COLOR OR RACE<br><u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1890 ?</u> | 9. AGE (In years last birthday)<br><u>70 yrs.</u>  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>7</u> | IF UNDER 24 HRS.<br>Hours <u>7</u> Min. <u>7</u>                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>at Home</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>  |                                   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                              |  |
| 13. FATHER'S NAME<br><u>Alexander Askins</u>   |                              |   |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Agnes ?</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>none</u>  |                                   | 17. INFORMANT<br><u>Howard Askins Ave. S. Spring (son)</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardiovascular Disease</u><br>(c) <u>stroke the underlying cause last.</u> DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><u>Atrial Fibrillation</u> |                              |   |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><u>36 hours</u><br><u>Unknown</u>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept - 8, 1961</u> to <u>Sept 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 9, 1961</u> , and that death occurred at <u>12:30 AM</u> from the causes and on the date stated above.  |                              |   |                                   |  |  |   |  |
| 22a. SIGNATURE<br><u>Gene U. Cohen, MD</u> M.D.  |                              |   |                                   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 22b. DATE SIGNED<br><u>Sept 10, 1961</u>                                |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>GENE U. COHEN, M.D.</u>   |                              |   |                                   | 22d. ADDRESS<br><u>931 PERSHING DR., SILVER SPRING MD</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>9-13-61</u>   |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ask. Memorial</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Sandy Spring, MD</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert L. Snowden</u>   |                              |   |                                   | ADDRESS<br><u>Rockville Md.</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 13 '61</u>                       |  |
|  |                              |   |                                   | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Huns</u>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10317

10312

|  |                                      |   |  |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>2 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U. S. Naval Hospital</b>  |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>District of Columbia</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b><br>d. STREET ADDRESS<br><b>3040 Fox Hall Rd. N. W.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Hilda Janson Barringer</b>  |                                      | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>7</b> Year <b>19 61</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>10-29-96</b>              |
| 9. AGE (In years last birthday)<br><b>64 yrs.</b>  |                                      | IF UNDER 1 YEAR<br>Months <b>64</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Washington, D. C.</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>USA</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Ernest N. Janson</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Eberly</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>   |                                      | 16. SOCIAL SECURITY NO.<br><b>579 56 5689 (H)</b>   |  |
| 17. INFORMANT<br><b>Victor C. Barringer</b>  |                                      | Address<br><b>Same as #2 above</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Adeno Carcinoma, metastatic</b><br>DUE TO<br>(c) <b>Adenocarcinoma, Primary Pancreas</b> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b><br><b>3 mos</b><br><b>6 mos</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <b>TH</b> (this hospital) attended the deceased from <b>September 5, 19 61</b> to <b>September 7, 19 61</b> that <b>TH</b> (we) last saw the deceased alive on <b>September 7, 19 61</b> , and that death occurred at <b>12:50</b> , from the causes and on the date stated above.  |                                      |   |  |
| 22a. SIGNATURE<br><b>Thomas B. Leberherz</b> M.D.  |                                      | 22b. DATE SIGNED<br><b>September 8, 1961</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>THOMAS B. LEBHERZ, CAPT MC USN</b>  |                                      | 22d. ADDRESS<br><b>U. S. Naval Hospital, Bethesda, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                      | 23b. DATE THEREOF<br><b>11 Sept 1961</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |                                      | 23d. LOCATION (City, town or county) (State)<br><b>Arlington Va.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |                                      | 25a. REC'D BY REGISTRAR<br><b>SEP 13 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>   |                                      | 25c. ADDRESS<br><b>7557 Wisconsin Ave. Bethesda, Md.</b>  |  |

101501

1350

M

1351 Wisconsin Ave. N. W., Wash., D. C.

George V. P. [unclear]

James E. [unclear]



FOR STATE  
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Medical Director or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10318 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10313

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution on date of death, give name of institution)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b   |  |   |  | d. STREET ADDRESS <u>18521 Murrub Rd.</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8521 Murrub Rd</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>ANNA</u> First <u>Beider</u> Middle Last  |  | 4. DATE OF DEATH<br><u>Sept 24</u> Month Day <u>1961</u> Year   |  | 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>                                      |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH <u>July 7, 1896</u>  |  | 9. AGE (In years last birthday) <u>65</u> yrs.   |  | IF UNDER 1 YEAR: Months Days                                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Drug</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>New York</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>                          |  |
| 13. FATHER'S NAME <u>Leon Beider</u>  |  |   |  | 14. MOTHER'S MARRIED NAME <u>Bertha Friedman</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>099-070-050A</u>  |  |  |  |
| 17. INFORMANT <u>Leonard C. Trenbaum</u>  |  |   |  | Address <u>6902 Bardu Ave. West Springfield, Va.</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u>  |  |   |  |  |  |  |  |
| DUE TO (b) <u>Coronary Occlusion</u>  |  |   |  |  |  |  |  |
| DUE TO (c) <u>Coronary Arteriosclerosis</u>   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Recent Myocardial Infarction</u> (b) <u>Carcinoma of Rectum</u>   |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. TIME OF INJURY<br>Hour <u>4:20</u> a.m. p.m. 19 <u>61</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | DATE SIGNED <u>9-25-61</u>   |  |  |  |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| Address (Street, city, town, or county)   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF <u>9/27/61</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>DETH SHOLOMON</u>  |  | 22d. LOCATION (City, town, or country) (State) <u>GA. 115. Md.</u> |  |
| 23. FUNERAL DIRECTOR <u>Gedberg Funeral Home</u>  |  |   |  | ADDRESS <u>4217-9th</u>  |  |  |  |
| 24a. REC'D BY REGISTRAR <u>SEP 27 '61</u>   |  |   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>  |  |  |  |

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

Reg. Dist. No.

10319

10314

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence (care admission))<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Silver Spring</i>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Silver Spring</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>McNair Bldg 10620 Georgia Ave.</i>  |  | d. STREET ADDRESS<br><i>1500 Gridley Lane</i>  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><i>Suzanne L. Belhumeur</i>   |  | 4. DATE OF DEATH Month Day Year<br><i>Sept 8 1961</i>  |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>25 Aug '58</i>                                     |
| 9. AGE (In years last birthday) yrs.<br><i>3</i>   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><i>3</i>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Infant</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>-----</i>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Takoma Park, Md.</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 13. FATHER'S NAME<br><i>Jean M. Belhumeur Jr.</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Lea Dextraze</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>NE</i>   |  | 16. SOCIAL SECURITY NO.<br><i>None</i>   |   |
| 17. INFORMANT<br><i>Mr Jean M. Belhumeur</i>   |  | Address<br><i>1500 Gridley Lane SS Md.</i>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>pulmonary Edema</i><br>DUE TO <i>4</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Congenital Heart Disease</i><br>DUE TO <i>Birth</i><br>(c) <i>Mongoloid</i><br>DUE TO <i>Birth</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Brone hits</i><br>INTERVAL BETWEEN ONSET AND DEATH<br><i>1 day</i><br><i>Birth</i><br><i>Birth</i> |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><i>19</i>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                      |
| 21. I certify that I attended the deceased from <i>25 Aug</i> 19 <i>58</i> , to <i>2 Sept</i> 19 <i>61</i> , that I last saw the deceased alive on <i>June</i> 19 <i>61</i> , and that death occurred at <i>6:00 P</i> M, from the causes and on the date stated above.  |  |  |   |
| ACTUAL SIGNATURE<br><i>Merton L. White</i>   |  | DATE SIGNED<br><i>8 Sept '61</i>   |   |
| PHYSICIAN'S NAME (Type)<br><i>Merton L. White M.D.</i>   |  | ADDRESS (Street, city or town, state)<br><i>11134 Georgia Ave Silver Spring Md.</i>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><i>8/11/61</i>  | 22c. NAME OF CEMETERY OR CREMATORY<br><i>REXKIKON Gate of Heaven</i>   | 22d. LOCATION (City, town, or county) (State)<br><i>Silver Spring Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Warner E. Pumphrey</i>  |  | 24a. REC'D BY REGISTRAR<br><i>SEP 13 '61</i>   |   |
| ADDRESS<br><i>8434 Ca Ave SS Md.</i>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>William S. Pumphrey</i>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FEDERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

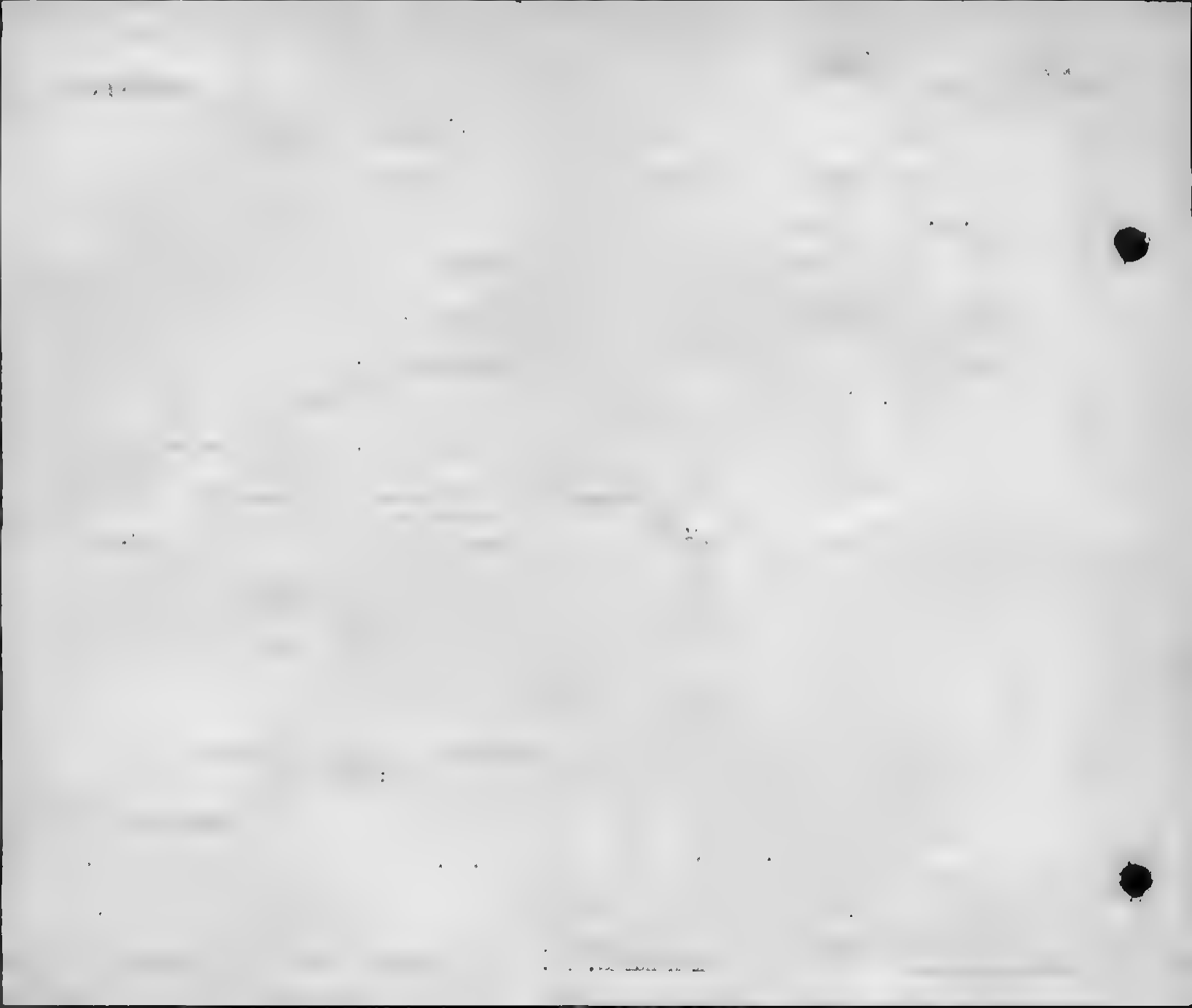
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10320

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |  |   |  |  |  |   |
|---|--|---|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN lb<br><u>11 day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>U. S. Naval Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, list hospital and give admission)<br>a. STATE<br><u>Virginia</u><br>b. COUNTY<br><u>Alexandria</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>411 Crownview Drive</u><br>d. STREET ADDRESS<br><u>September 8, 1961</u> |  | 10315  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><u>Andrew</u><br>Middle<br><u>Curtis</u><br>Last<br><u>Bigelow</u>  |  | 4. DATE OF DEATH<br>Month<br><u>September</u><br>Day<br><u>9</u><br>Year<br><u>1961</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>Caucasian</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Infant</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Bethesda, Md.</u>   |  | 9. AGE (In years last birthday)<br><u>1</u> yrs. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>                           |  |   |
| 13. FATHER'S NAME<br><u>LaVell M. Bigelow</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Avalon Christensen</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>(Father) LaVell M. Bigelow Same as #2 above</u><br>Address   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><u>Respiratory distress syndrome</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>13 hrs 27 min</u>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)   |  | 20g. (County)  |  | 20h. (State)  |
| 21. I certify that <u>Dr. (this hospital)</u> attended the deceased from <u>September 8, 1961</u> to <u>September 9, 1961</u> that <u>(s)</u> (we) last saw the deceased alive on <u>September 9 1961</u> and that death occurred at <u>11:09 PM</u> from the causes and on the date stated above.  |  | 22a. SIGNATURE<br><u>Robert V. Rack</u><br>22c. PHYSICIAN'S NAME (Type)<br><u>ROBERT V. RACK, LT MC USN</u>   |  | 22b. DATE SIGNED<br><u>September 9, 1961</u>   |  | 22d. ADDRESS<br><u>U. S. Naval Hospital, Bethesda, Md.</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>14 Sep 1961</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>  |  | 23d. LOCATION (City, town or county)<br><u>Arlington</u><br>(State)<br><u>Va.</u>                         |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Cummingham Funeral Home</u>  |  | ADDRESS<br><u>809 Cameron St. Alexandria, Va.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>SEP 13 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Cummingham</u>   |



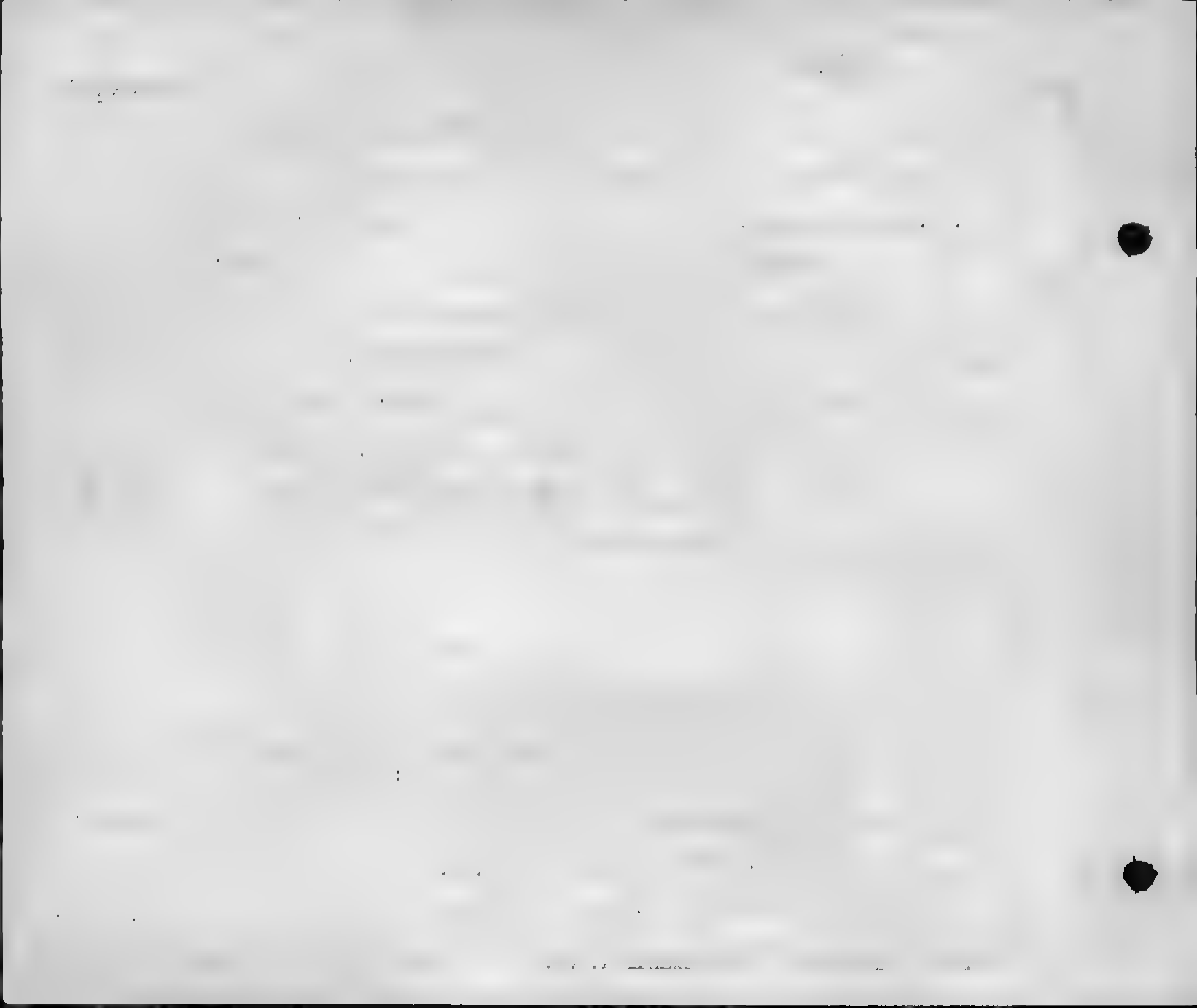


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                   |  |  |  |  |  |   |  |   |  |
|--|--|-----------------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                   |  |  |  |  |  |   |  |   |  |
| 10321 CERTIFICATE OF DEATH 10316   |  |                                   |  |  |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |  |                                   |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>Virginia</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> |  |  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>   |  |                                   |  | c. LENGTH OF STAY IN 1b <u>1 day</u>   |  |  |  | d. STREET ADDRESS <u>411 Crownview Drive</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>   |  |                                   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 4. DATE OF DEATH <u>September 8, 1961</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Joseph Alfonso Bigelow</u>  |  | 5. SEX <u>Male</u>                |  | 6. COLOR OR RACE <u>Caucasian</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>September 8, 1961</u>   |  | 9. AGE (In years last birthday) <u>6 yrs.</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Hours Min.                |  |
| 13. FATHER'S NAME <u>LaVell M. Bigelow</u>   |  |                                   |  | 14. MOTHER'S MAIDEN NAME <u>Avalon Christensen</u>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>                                       |  |   |  |
| 16. SOCIAL SECURITY NO. <u>(Father) LaVell M. Bigelow Same as #2 above</u>   |  |                                   |  | 17. INFORMANT <u>LaVell M. Bigelow</u>   |  |  |  | Address <u>Same as #2 above</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Respiratory distress of Newborn</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Prematurity</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 hr.</u><br><u>6 hr. 29 min.</u> |  |                                   |  | INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>September 8, 1961</u><br>Hour a.m. <u>3:10 AM</u> p.m. <u>19</u>   |  |                                   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hospital, Bethesda, Md.</u> |  |   |  |
| 20f. (City or town) <u>Arlington</u>   |  |                                   |  | 20g. (County) <u>Virginia</u>  |  |  |  | 20h. (State) <u>Va.</u>   |  |   |  |
| 21. I certify that (M) (this hospital) attended the deceased from <u>September 8, 1961</u> to <u>September 9, 1961</u> that (X) (we) last saw the deceased alive on <u>September 9, 1961</u> , and that death occurred at <u>3:10 AM</u> from the causes and on the date stated above.   |  |                                   |  |  |  |  |  |   |  |   |  |
| 22a. SIGNATURE <u>Lawrence G. Thorne</u>   |  |                                   |  | 22b. DATE SIGNED <u>11 September 1961</u>  |  |  |  | 22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE G. THORNE, LT MC USN</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                                   |  | 23b. DATE THEREOF <u>14 Sep 1961</u>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>  |  |   |  |
| 23d. LOCATION (City, town or county) <u>Arlington</u>  |  |                                   |  | 23e. (State) <u>Va.</u>  |  |  |  | 23f. (Country) <u>USA</u>   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Cunningham Funeral Home, 809 Cameron St. Alexandria, Va.</u>   |  |                                   |  | 25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>John S. Kenna</u>   |  |   |  |

2251397XV2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

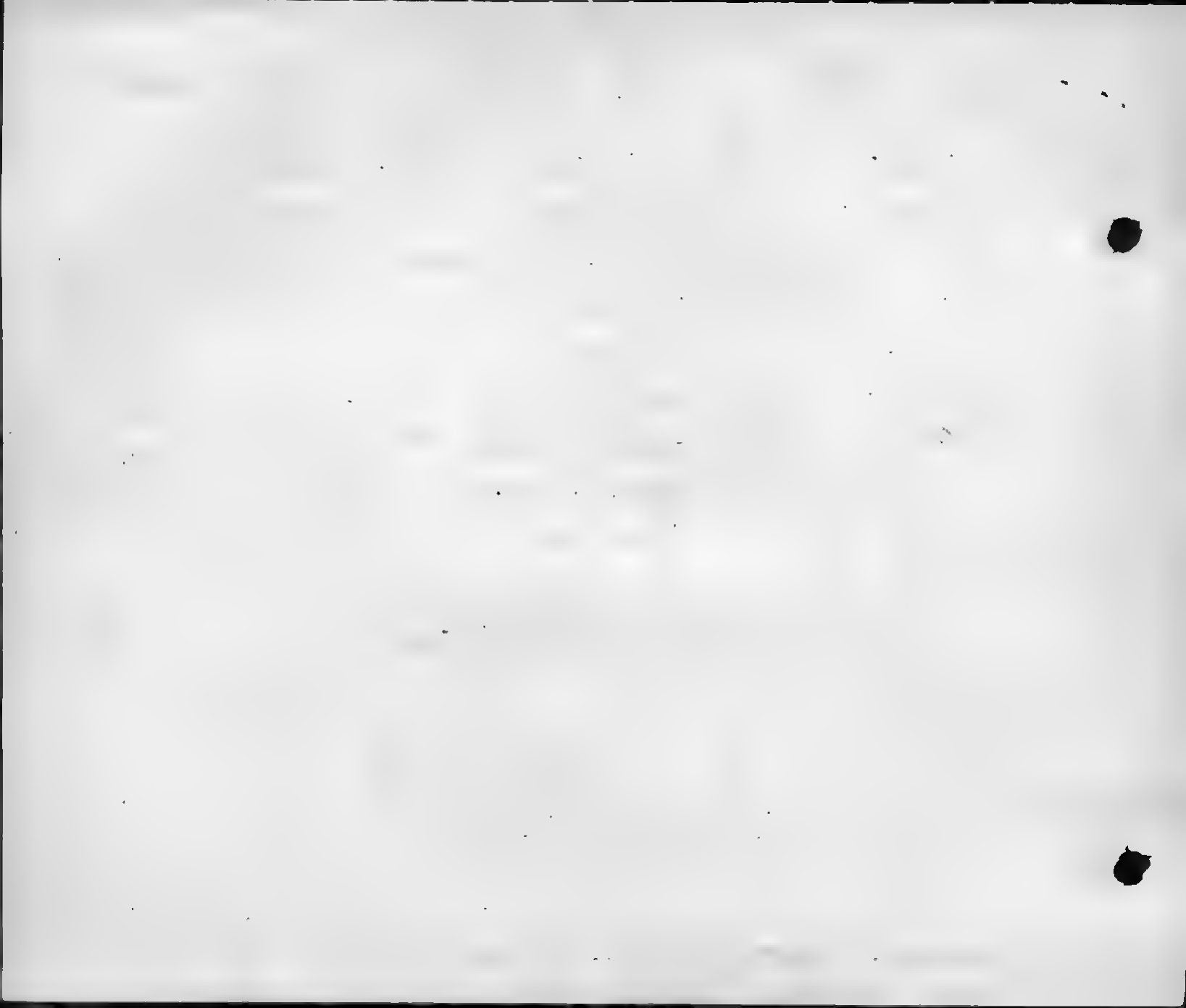
VR A15 (4)  
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10322

10317

|   |                              |  |  |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>D.C.</b><br>b. COUNTY                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL OLNEY</b>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>   |  |
| c. LENGTH OF STAY IN 1b <b>8 Mos</b>  |                              | d. STREET ADDRESS <b>40 PLATTSBURG ST. NW</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BACOE GROVE FOUNDATION</b>  |                              | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDNA</b> Middle <b>G</b> Last <b>BLAIR</b>  |                              | 4. DATE OF DEATH<br>Month <b>SEPT</b> Day <b>7</b> Year <b>1961</b>  |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>CAUC</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>30 MAY 1892</b> 69 yrs |
| 9. AGE (In years last birthday) <b>69</b>   |                              | 10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>9</b> Hours <b>0</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>  |                              | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>PETER D. GIBBS</b>   |                              | 14. MOTHER'S MAIDEN NAME <b>KATE PHALEN</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>  |                              | 16. SOCIAL SECURITY NO. <b>450-28-6122</b>   |  |
| 17. INFORMANT <b>Mrs. RALPH W. RYAN</b>   |                              | Address <b>6100 WILSON LANE BETHESDA</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIA</b><br>600.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PROBABLE ACUTE PYELONEPHRITIS 3 wks</b><br>DUE TO (c) |                              |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARKINSON'S DISEASE</b>  |                              |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                              | 20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>1/1/61</b> to <b>9/7</b> 19 <b>61</b> that (1) <b>last</b> saw the deceased alive on <b>9/5</b> 19 <b>61</b> and that death occurred at <b>3:55</b> M, from the causes and on the date stated above.   |                              |  |  |
| 22a. SIGNATURE <b>John P. Martin, MD</b>  |                              | 22b. DATE SIGNED <b>9/7/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>JOHN P. MARTIN, MD</b>  |                              | 22d. ADDRESS <b>MEDICAL CENTER, SANDY SPRING</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>  |                              | 23b. DATE THEREOF <b>9/7/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>  |                              | 23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>  |                              | ADDRESS <b>Bethesda, Maryland</b>  |  |
| 25a. REC'D BY REGISTRAR <b>SEP 8 '61</b>  |                              | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

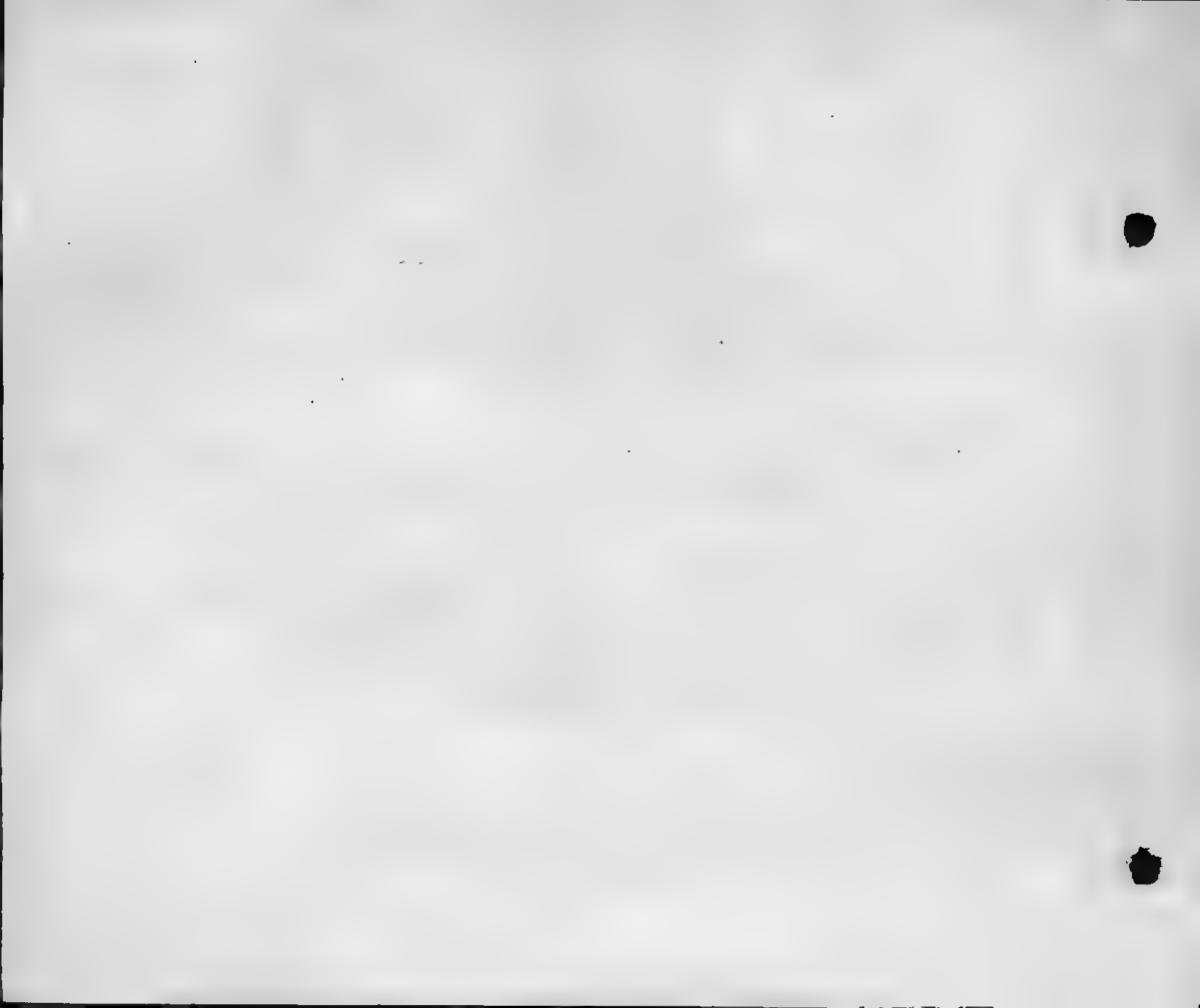
## 10323 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

|   |   |  |                                      |
|---|---|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution, give address) <u>10318 D.C.</u>  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San + Hosp</u>   |   | d. STREET ADDRESS <u>1650 Pontal Dr NW</u>   |                                      |
| 3. NAME OF DECEASED (Type or print) <u>JACK Scheffler</u>   |   | 4. DATE OF DEATH <u>9-25-61</u>  |                                      |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-4-03</u>      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>   |   | 11. BIRTHPLACE (State or foreign country) <u>New York</u>  |                                      |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>House Recording Studio</u>   |   | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |                                      |
| 13. FATHER'S NAME <u>Max Bohrer</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Dora Scheffler</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>   |   | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO (b) <u>412</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Stroke</u>  |   | 17. INFORMANT <u>MRS. SARA K.</u> Address <u>Same as above.</u>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |                                      |
| 2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 2Dc. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. <u>19</u>  | 2Dd. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 2Df. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |                                      |
| ACTUAL SIGNATURE <u>Frank J. Broschalt</u>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschalt</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |   | 22b. DATE THEREOF <u>9-28-61</u>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN-FALLS CHURCH-VA.</u>   |   | 22d. LOCATION (City, town, or country) (State) <u>VA.</u>  |                                      |
| 23. FUNERAL DIRECTOR <u>Bernard Danzansky + Sons - 3501-14th St</u>   |   | 24a. REC'D BY REGISTRAR <u>SEP 29 '61</u>  |                                      |
|   |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. H...</u>   |                                      |





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10324

10319

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b><br>c. LENGTH OF STAY IN 1b<br><b>2</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2 Lauer Terrace</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b><br>d. STREET ADDRESS <b>2 Lauer Terrace</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>EDGAR</b> Last <b>BOYLAND</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>21</b> Year <b>1961</b>   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>6-4-1882</b>                                       |  |
| 9. AGE (in years last birthday) <b>79</b>   |  | 10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>   |  | 11. IF UNDER 24 HRS Hours <b>10</b> Min. <b>0</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Contractor</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Heating &amp; Plumbing/ Washington, D.C.</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>      |  |
| 13. FATHER'S NAME <b>John Boyland</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Nellie O'Brien</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>---</b>   |  | 17. INFORMANT <b>Mary Young Boyland, 2 Lauer Terrace</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>527.1</b> DUE TO <b>Cerebral anoxia</b><br>Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pulmonary embolism</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)            |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>present</b> that (I) (we) last saw the deceased alive on <b>Sept 20 1961</b> , and that death occurred at <b>12:00 M.</b> from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| 22a. SIGNATURE <b>Clifford K. Boyland</b> M.D.  |  |  |  | 22b. DATE SIGNED <b>9/21/61</b>   |  | 22c. PHYSICIAN'S NAME (Type) <b>915 19th St. NW, Wash DC</b>           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>9-25-1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaudin &amp; Son, Inc. 1756 Pa. Ave. NW</b>  |  |  |  | 25a. REC'D BY REGISTRAR <b>SEP 25 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                      |  |

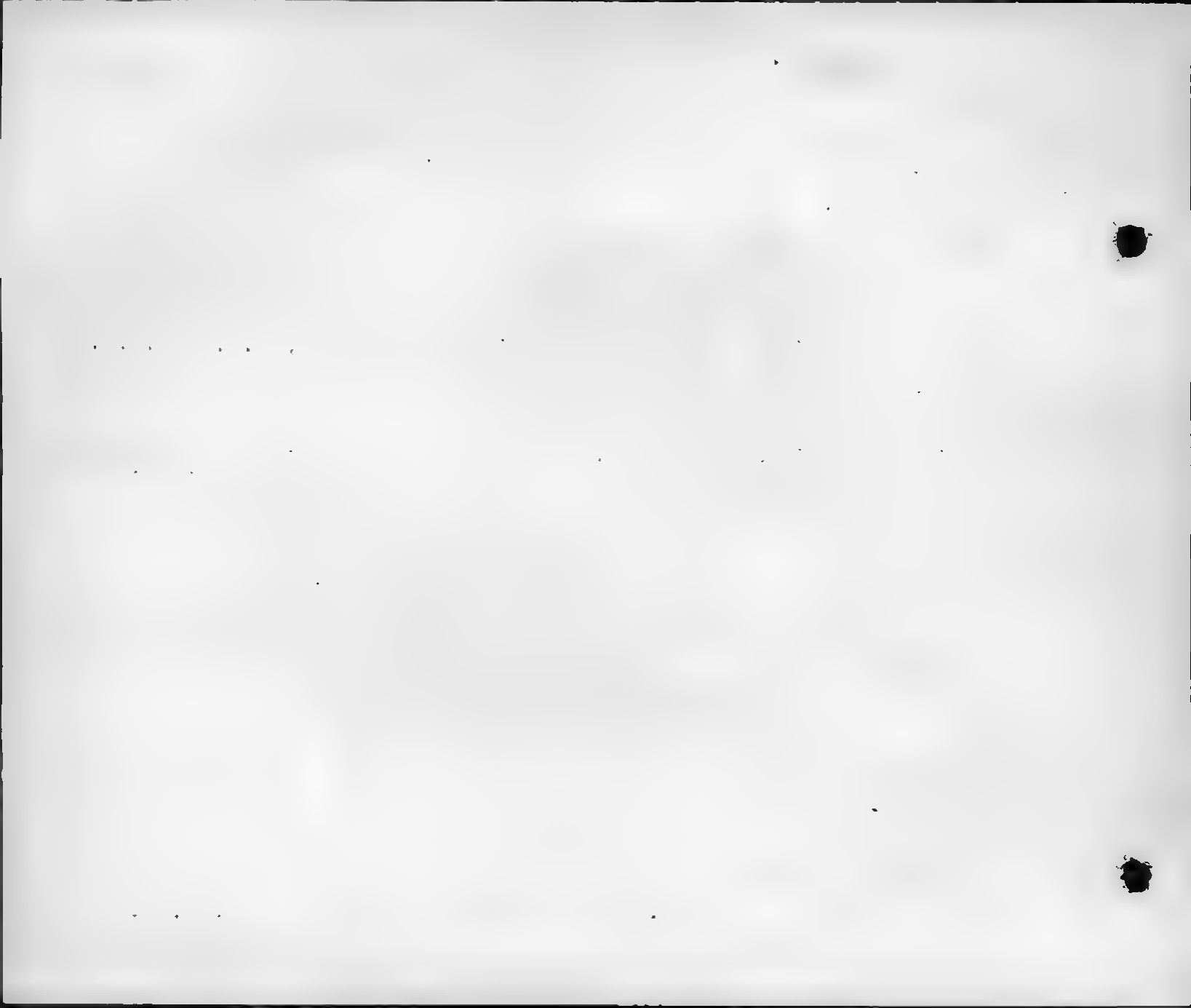
MEDICAL CERTIFICATION

Cemeteries notified & will app. 10/1/61

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

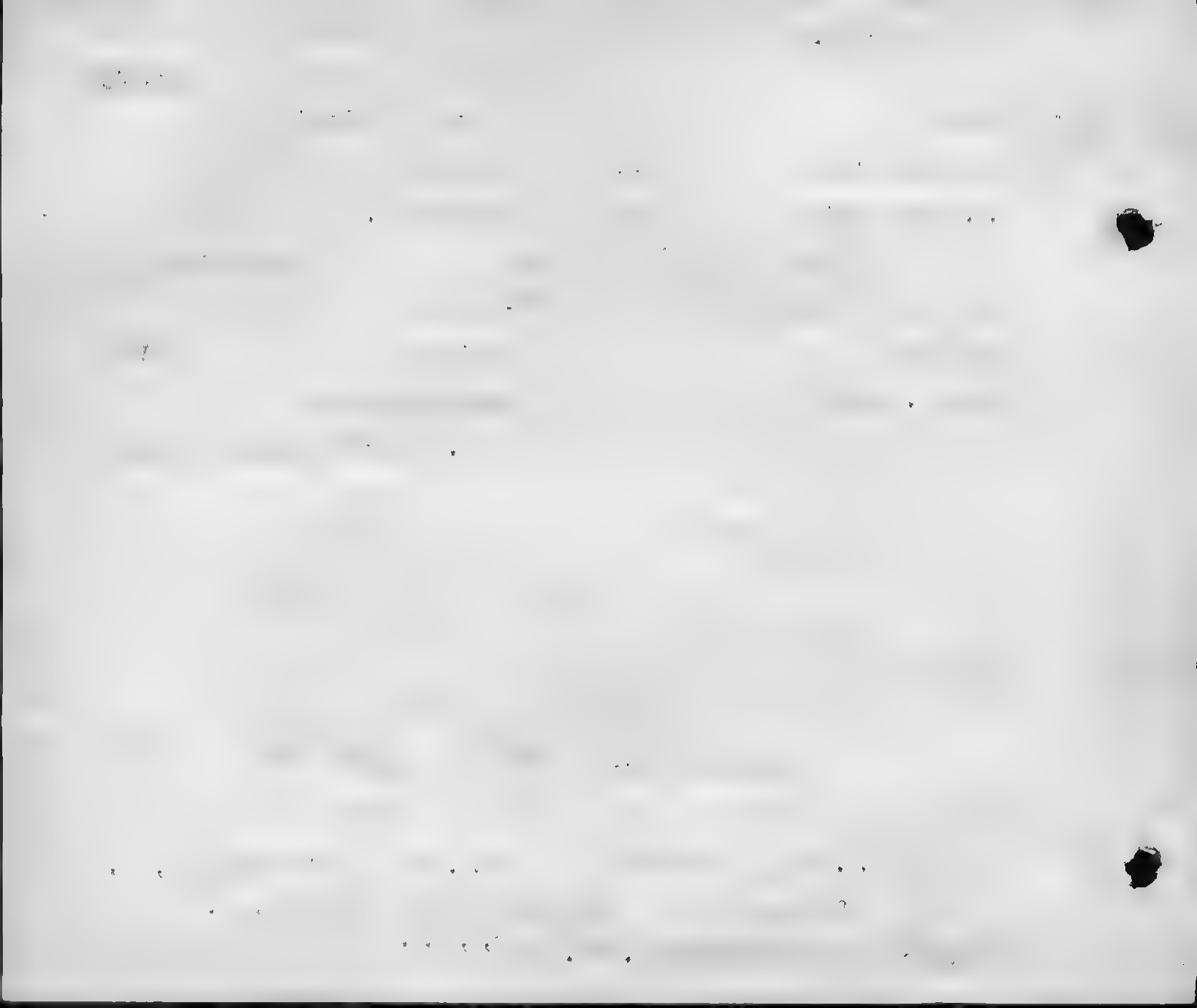
## CERTIFICATE OF DEATH

Item 9 Film G295 9/21/61 wk

|  |   |   |                                      |
|--|---|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution, include name and address on)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>District of Columbia</b> |                                      |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |                                      |
| c. LENGTH OF STAY in 1b<br><b>5 days</b>   |   | d. STREET ADDRESS<br><b>4413 46th St. NW</b>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U.S. Naval Hospital</b>   |   | b. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Overton (N) Brooks</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>September 16 19 61</b>   |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Caucasian</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>12-12-97</b>  |
| 9. AGE (In years last birthday)<br><b>62 63</b>  |   | 10. UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Congressman</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Louisiana</b>   |                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 13. FATHER'S NAME<br><b>Claude M. Brooks</b>  |                                      |
| 14. MOTHER'S MAIDEN NAME<br><b>Penelope Overton</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes</b>   |                                      |
| 16. SOCIAL SECURITY NO.<br><b>Mollie M. Brooks (W) Same as #2 above</b>  |   | 17. INFORMANT<br><b>Mollie M. Brooks (W) Same as #2 above</b>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>43 } DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b><br>(c) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>years</b>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State) |
| 21. I certify that (a) (this hospital) attended the deceased from <b>Sept 11</b> 1961 to <b>Sept 16</b> 1961, that (b) (we) last saw the deceased alive on <b>September 16 1961</b> , and that death occurred at <b>1109</b> from the causes and on the date stated above.   |   |   |                                      |
| 22a. SIGNATURE<br><b>L. N. Cahill</b>  |   | 22b. DATE SIGNED<br><b>Sept 16 1961</b>   |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. N. CAHILL LCDR MC USN</b>  |   | 22d. ADDRESS<br><b>U.S. Naval Hospital Bethesda, Md.</b>  |                                      |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF<br>REMOVAL (Specify)<br><b>Burial 20 September 1961</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Hills</b>   |                                      |
| 23d. LOCATION (City, town or county) (State)<br><b>Shreveport, La.</b>   |   | 23e. REC'D BY REGISTRAR<br><b>SEP 19 '61</b>  |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gawler Funeral Home 1756 Penn. Ave. NW</b>  |   | 25. REGISTRAR'S SIGNATURE<br><b>William S. Thomas</b>   |                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

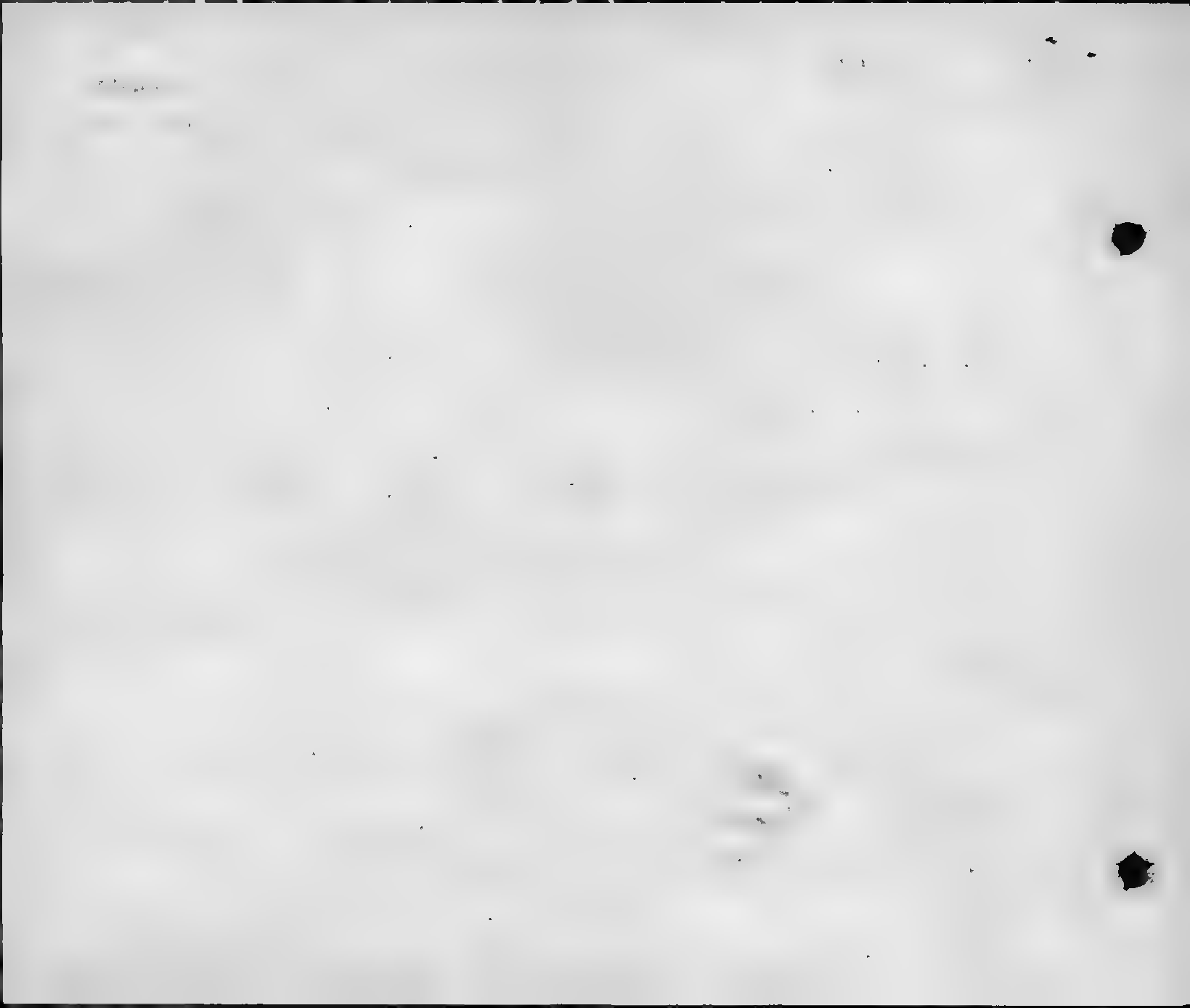
10326

10321

|   |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>  |  | c. LENGTH OF STAY (in hrs)<br><b>1102 Edmonston Drive</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if inst. funeral residence, or place of admission)<br>a. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Montgomery</b>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b> |  | d. STREET ADDRESS<br><b>1102 Edmonston Drive</b>    |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Garnett R Brown</b>  |  | 4. DATE OF DEATH<br><b>September 4 1961</b>   |  | 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                   |  | 8. DATE OF BIRTH<br><b>10/6/91</b>   |  | 9. AGE (in years last birthday)<br><b>69 yrs.</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>28</b> Hours <b></b> Min. <b></b>  |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U. S. Gov't</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Davis A. Brown</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Edwards</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>WW 1</b> |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Helen C. Brown-Wife-same</b>    |  | 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Metastasis &amp; Hemorrhage</b><br>157X DUE TO (b) <b>adenocarcinoma of Pancreas</b><br>DUE TO (c) <b></b> |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b>   |  | 20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> |  | 21. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 22. MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b></b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |   |  |  |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1961</b> to <b>Sept 4 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept 3 1961</b> , and that death occurred at <b>Rockville</b> , from the causes and on the date stated above. |  | 22a. SIGNATURE<br><b>William Frank</b>  |  | 22b. DATE SIGNED<br><b>9/4/61</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>WILLIAM FRANK, M.D.</b>   |  | 22d. ADDRESS<br><b>344 W. MONTGOMERY AVE ROCKVILLE, MD.</b>   |  | 22e. REC'D BY REGISTRAR<br><b>SEP 7 '61</b>  |  | 22f. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b> |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/7/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat. Cem.</b>                                  |  | 23d. LOCATION (City, town or county) (State)<br><b>Arlington, Virginia</b>   |  | 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |  | 24b. ADDRESS<br><b>Bethesda, Maryland</b>  |  | 24c. DATE<br><b>SEP 7 '61</b>                       |  | 24d. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



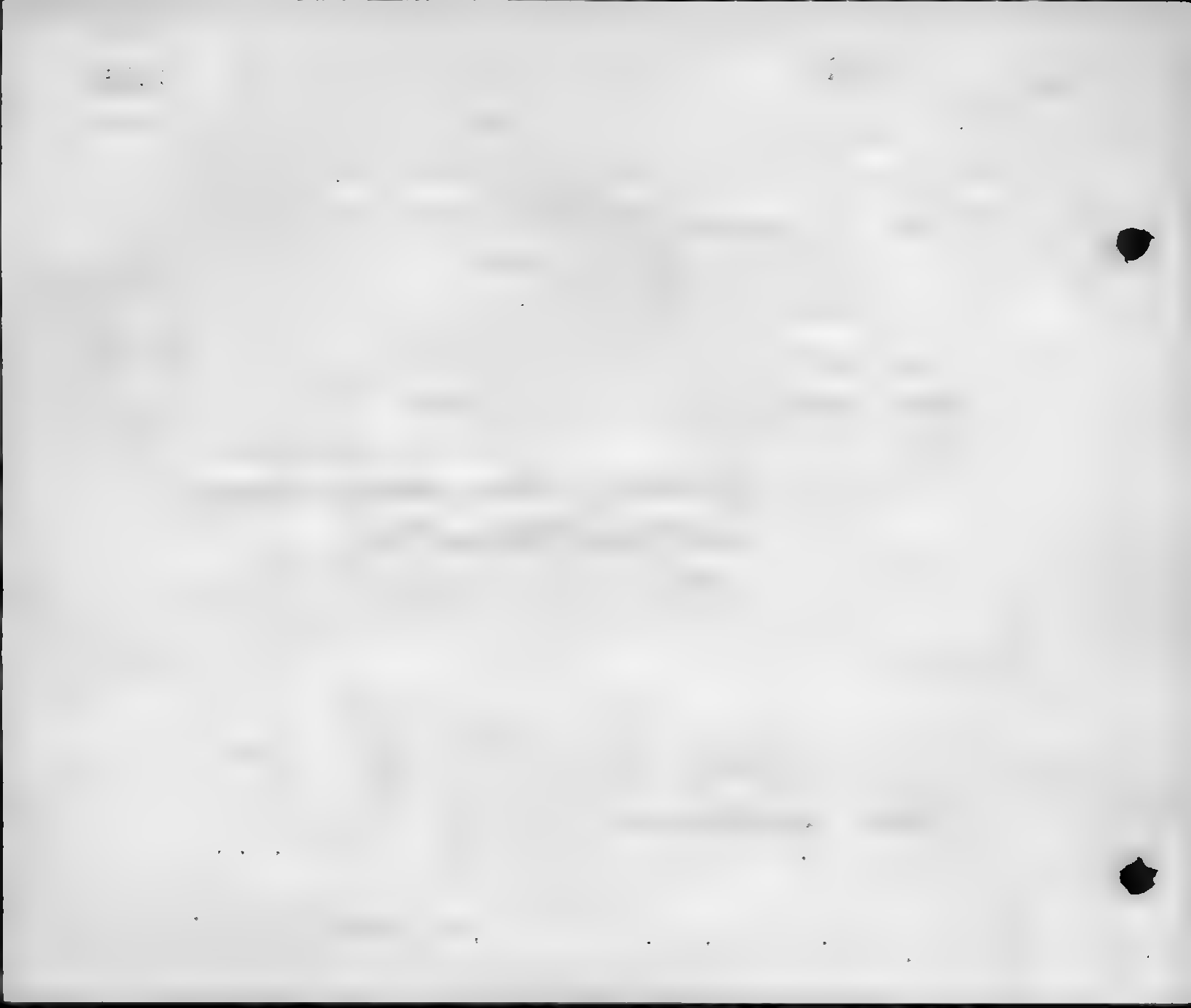


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10327  
10322

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>7 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>817 Northampton Dr.</u> |  |
| 3. NAME OF DECEASED (Type or print) <u>Verna Faye Brozak</u>  |  | 4. DATE OF DEATH <u>9 14 1961</u>   |  |
| 5. SEX <u>Fe</u>  |  | 6. COLOR OR RACE <u>White</u>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>1-30-'11</u>  |  |
| 9. AGE (In years last birthday) <u>50 yrs.</u>  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. of Defense</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>  |  |
| 13. FATHER'S NAME <u>Neil Underwood</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Nora Deale</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>1 Hospital Records</u>   |  |
| 17. INFORMANT <u>1 Hospital Records</u>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septic Shock (Endotoxin Syndrome)</u><br>DUE TO<br>(b) <u>Intestinal Obstruction</u><br>DUE TO<br>(c) <u>adhesions</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>adhesions</u> |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> <u>61</u> to <u>9/14</u> <u>61</u> that (I) (we) last saw the deceased alive on <u>9/13</u> <u>61</u> , and that death occurred at <u>4:48</u> <u>P.M.</u> from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <u>Lytle Williams</u>  |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>LYTLE W. WILLIAMS</u>   |  | 22d. ADDRESS <u>8700 Collesville Road, S.S.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>9/18/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Arlington Co. Virginia</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. Latta</u>  |  | 25. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>   |  |
| 25a. RECORD BY REGISTRAR <u>SEP 19 61</u>   |  | 25b. REGISTRAR'S SIGNATURE  |  |



10329

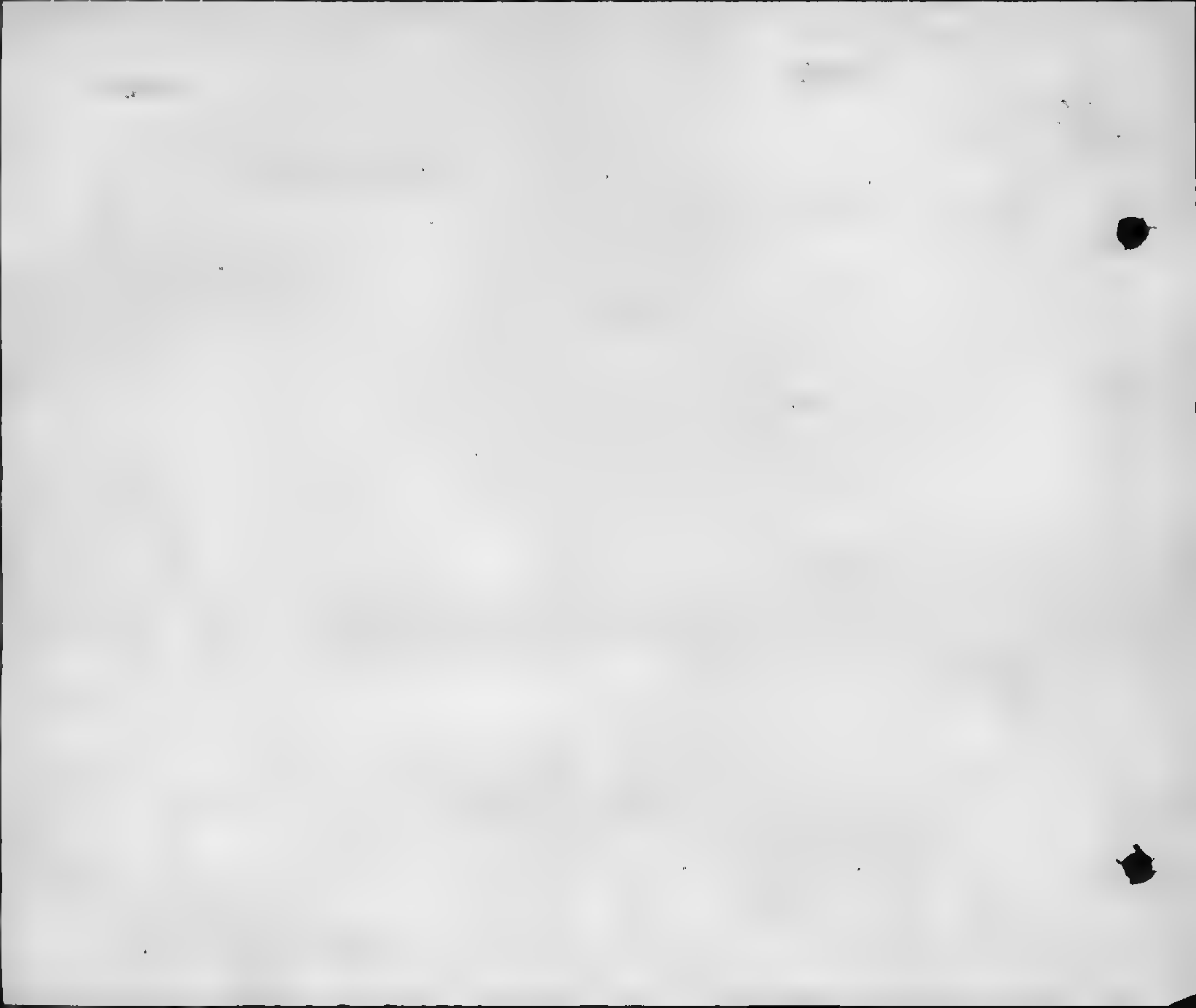
25b. REGISTRAR'S SIGNATURE \_\_\_\_\_

1/DATE **SEP 25 '61**

Arthur L. Knapp

2. 73151xv3

VR A15 (4)  
15M 9/60



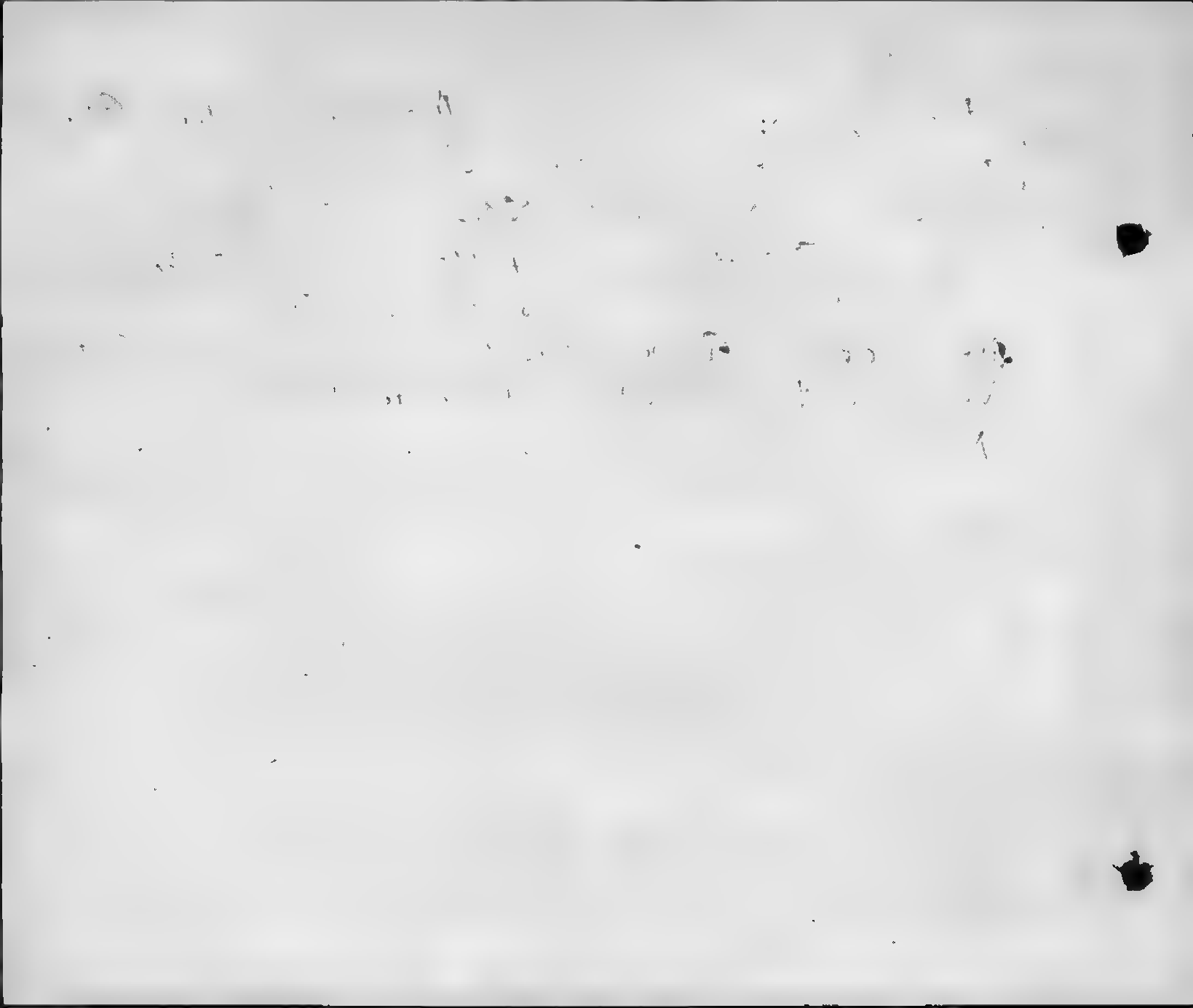
1  
FOR STATE  
HEALTH DEPT.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

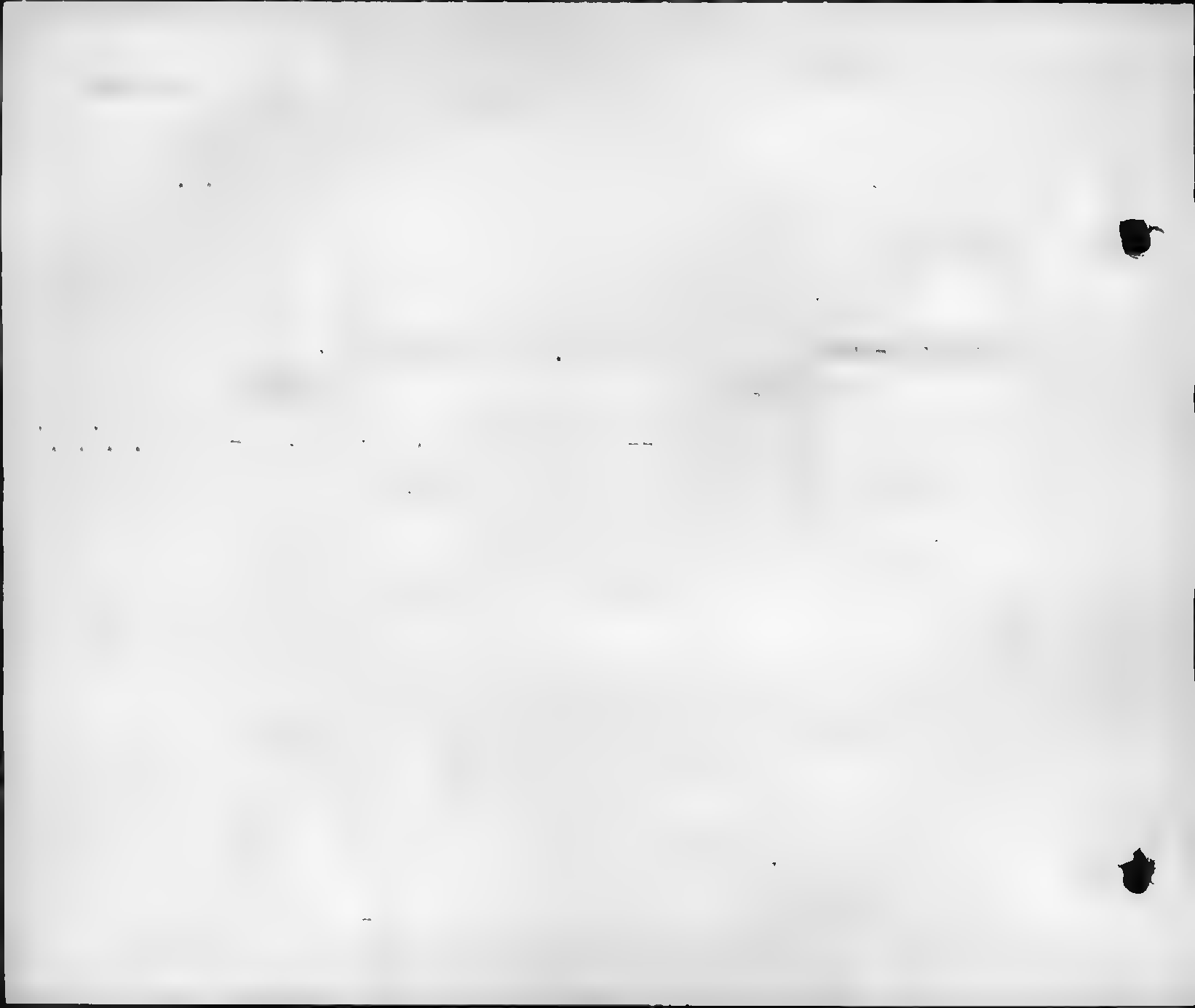
VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, give address, if not, give nearest town)     |  |  |  |
|---|--|--|--|--|--|--|--|
| a. COUNTY <u>Montgomery</u>   |  |  |  | a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Alpharetta</u>     |  |  |  |
| c. LENGTH OF STAY IN 1b <u>D.O.A.</u>   |  |  |  | d. STREET ADDRESS <u>8315 14th Ave.</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San &amp; Hosp</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Sherwood R Byrd</u>  |  |  |  | 4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1961</u>  |  |  |  |
| 5. SEX <u>M</u>   |  |  |  | 6. COLOR OR RACE <u>W</u>  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 8. DATE OF BIRTH <u>8-26-03</u> 9. AGE (In years last birthday) <u>58</u> yrs.                         |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Quebec Arms. W. Va.</u>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |  |  |
| 13. FATHER'S NAME <u>Walter R. Byrd</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Roberta Boswell</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>235-09-1297</u>   |  |  |  |
| 17. INFORMANT <u>Mrs. Minnie E. Byrd</u>  |  |  |  | Address <u>Hyattsville, Md. 8315 - 14th Ave.,</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>   |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>  |  |  |  |  |  |  |  |
| 43001 DUE TO  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (b) <u>43001</u>   |  |  |  |  |  |  |  |
| DUE TO (a), stating the underlying cause last.  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)            |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschani</u> M.D.   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschani</u>  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |  |  | 22b. DATE THEREOF <u>SEPT. 6, 1961</u>   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ROSELAWN MEMORIAL GARDENS</u>   |  |  |  | 22d. LOCATION (City, town, or country) (State) <u>BLUEFIELD, WEST VIRGINIA</u>                         |  |  |  |
| 23. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC., SILVER SPRING, MD.</u>  |  |  |  | 24a. REC'D BY REGISTRAR <u>SEP 6 '61</u>   |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>  |  |  |  | 24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |  |  |  |









# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10331

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10326

1. FOR STATE HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY N 1b

7 mo

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

7940 Old Georgetown Rd

### 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

a. STATE

MD

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

17940 Old Georgetown Rd

3. NAME OF DECEASED (Type or print)

Thomas Lee Campbell

4. DATE OF DEATH

Sept 3 1961

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Oct 30 1893

9. AGE (In years last birthday)

67 yrs

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machine

10b. KIND OF BUSINESS OR INDUSTRY

Typewriter

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August Campbell

14. MOTHER'S MAIDEN NAME

Mary Caviness

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

No

16. SOCIAL SECURITY NO

Unknown

17. INFORMANT

James Hatch - Son

18. CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary occlusion  
Hypertension

INTERVAL BETWEEN ONSET AND DEATH

sudden  
year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MED. CAL. EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

9-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Sept. 6, 1961

22c. NAME OF CEMETERY OR CREMATORY

Gross Hill Cemetery

22d. LOCATION (City, town, or county)

Santhage North Carolina

23. FUNERAL DIRECTOR

Robert A. Campbell

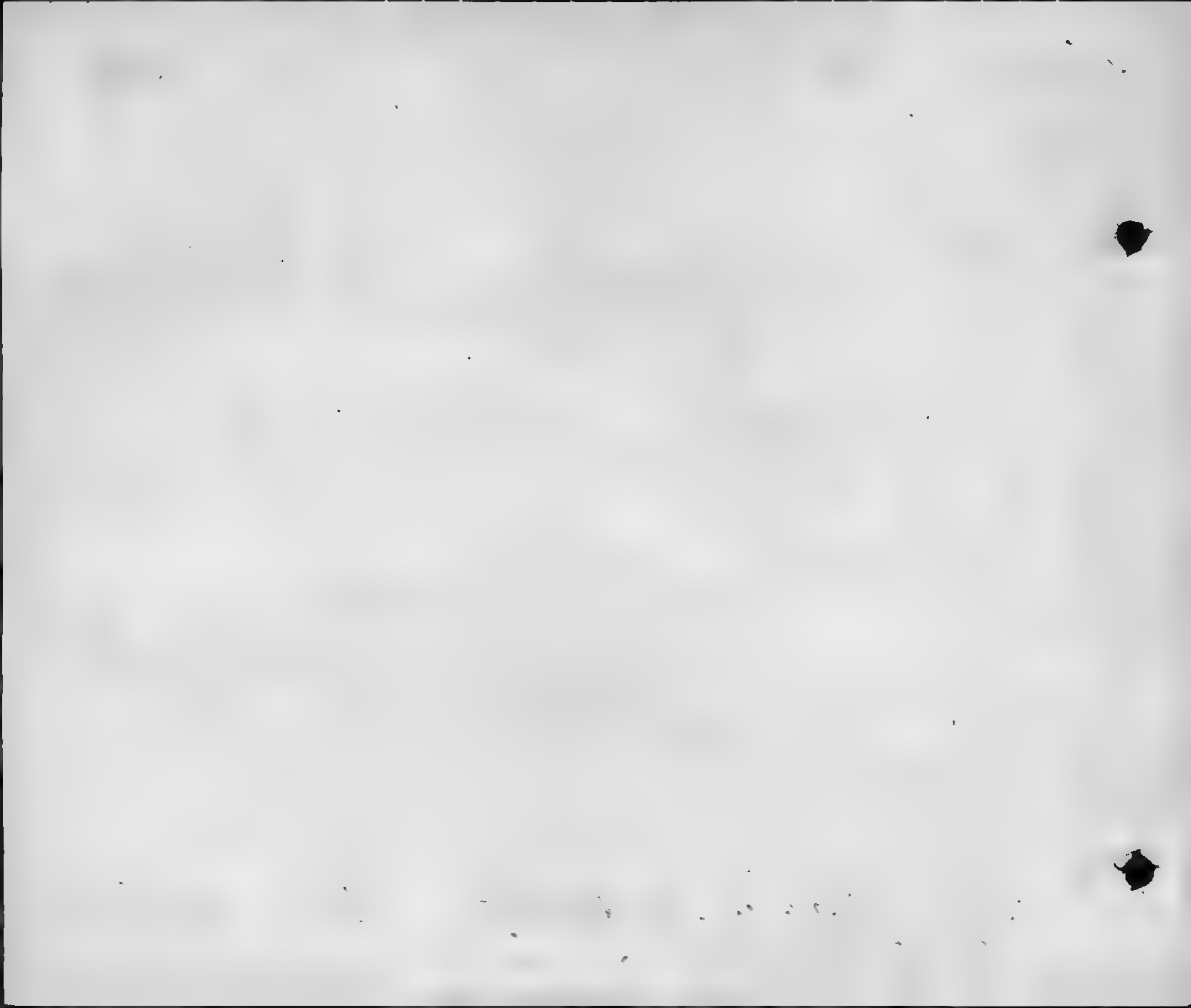
24a. REC'D BY REG. STRAR

DATE SEP 7 '61

24b. REGISTRAR'S SIGNATURE

William S. Thomas

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10332

## CERTIFICATE OF DEATH

10327

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b><br>c. LENGTH OF STAY IN b. <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b><br>d. STREET ADDRESS <b>519 N. Frederick Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First Middle Last<br><b>Sarah Frances Carnes</b>  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>Sept. 2 1961</b>  |  |
| <b>5. SEX</b><br><b>female</b>   |  | <b>6. COLOR OR RACE</b><br><b>white</b>   |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><b>10.6.1883</b>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Virginia</b>   |  |
| <b>13. FATHER'S NAME</b><br><b>George Myers</b>  |  | <b>14. MOTHER'S MARDEN NAME</b><br><b>Sarah Havener</b>   |  |

|   |  |  |
|---|--|--|
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>unknown</b> | <b>16. SOCIAL SECURITY NO.</b><br><b>unknown</b> | <b>17. INFORMANT</b><br><b>Hospital Records</b><br>Address |
|---|--|--|

|   |  |   |
|---|--|---|
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br>DUE TO <b>X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterial hypertension</b><br>DUE TO (c) <b>generalized arteriosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>30 years</b><br><b>30 years</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |

|   |  |  |
|---|--|--|
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)              |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m.<br>19  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office, etc.)<br><b>20f. (City or town)</b> (County) (State) |

|  |  |  |  |
|--|--|--|--|
| <b>21. I certify that (I) (this hospital) attended the deceased from..</b> <b>Jan 1958</b> <b>to Sept 3 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept 2 1961</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above. |  |  |  |
| <b>22a. SIGNATURE</b><br><b>Gordon S. Rosenberger</b><br><b>22b. NAME (Type)</b> <b>Gordon S. Rosenberger</b>  | <b>22c. ADDRESS</b><br><b>310 W. Montg. Ave. Gaithersburg, Md.</b> |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Buried</b>  |  | <b>23b. DATE THEREOF</b><br><b>9/5/61</b>                            |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Union Cemetery</b>   |  | <b>23d. LOCATION (City, town or county)</b><br><b>Rockville, Md.</b> |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Arthur S. Thoms</b>  |  | <b>25a. REC'D BY REGISTRAR</b><br><b>SEP 6 '61</b>                   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Thoms</b>  |  | <b>25c. ADDRESS</b><br><b>316 E. ... Gaithersburg, Md.</b>           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

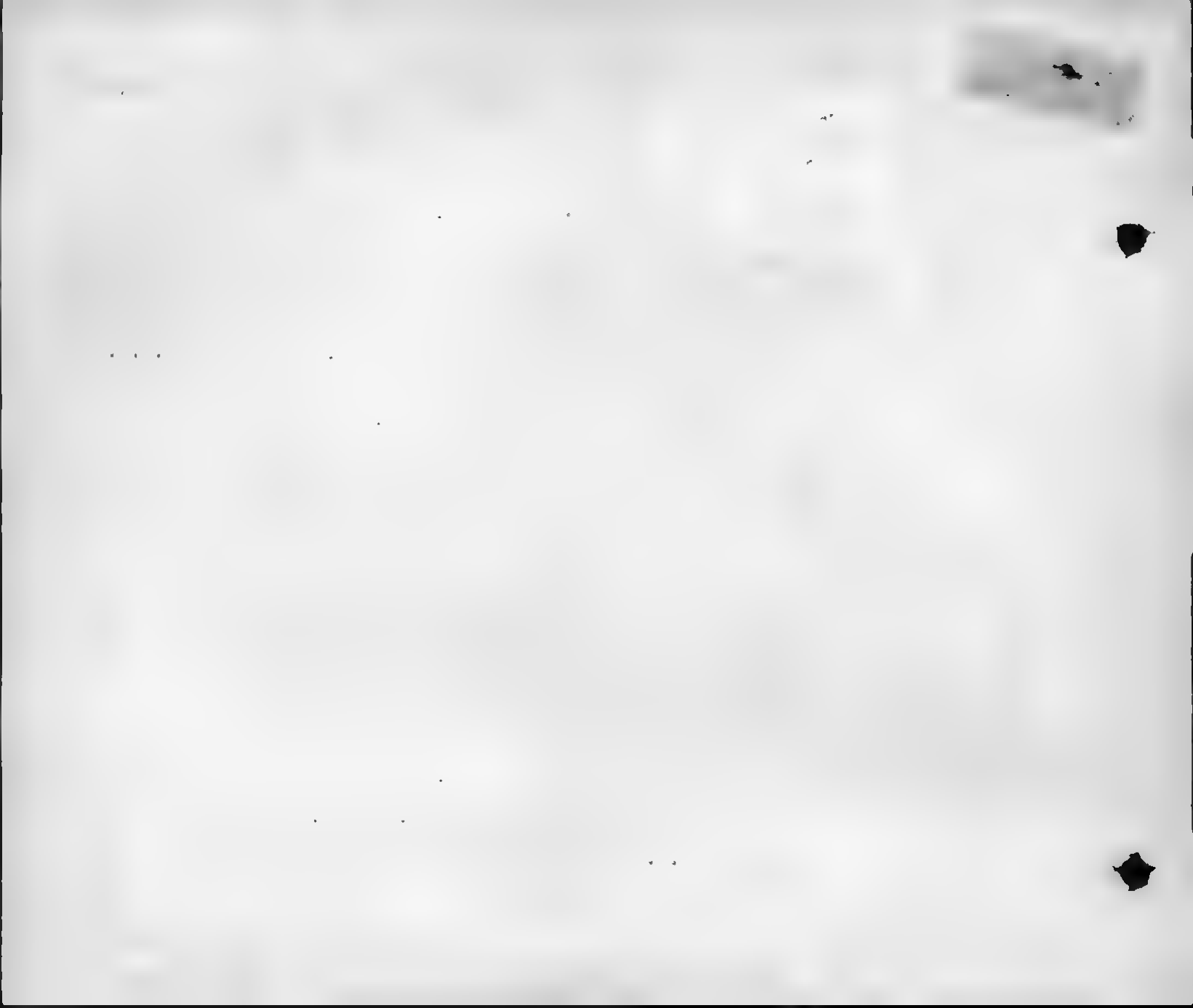
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10328

|   |  |  |  |   |  |  |
|---|--|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>44 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b> |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before institution)<br>a. STATE <b>North Carolina</b><br>b. COUNTY <span style="float: right;">✓</span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Winston-Salem</b><br>d. STREET ADDRESS<br><b>451 South Sunset Drive</b> |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First Middle Last<br><b>Martha Elizabeth Carrington</b>   |  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>September 22 19 61</b>   |   |  |  |
| <b>5. SEX</b><br><b>Female</b>  |  | <b>6. COLOR OR RACE</b><br><b>White</b>                  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  |  |
| <b>8. DATE OF BIRTH</b><br><b>November 27, 1898</b>   |  | <b>9. AGE</b> (In years last birthday) yrs.<br><b>62</b> |  | <b>10. IF UNDER 1 YEAR</b><br>Months Days Hours Min<br><b>19 61</b>   |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>None</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>North Carolina</b>                            |  |
| <b>13. FATHER'S NAME</b><br><b>Charles Swing</b>  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Joyce Staley</b>   |   |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |  | <b>16. SOCIAL SECURITY NO</b><br><b>Not available</b>  |   | <b>17. INFORMANT</b> The Medical Record Address<br><b>The Clinical Center, Bethesda 14, Maryland</b> |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Esophageal carcinoma with respiratory obstruction</b><br><b>150X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b>  |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <b>19</b><br><b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |  |  |  |  |  |
| <b>21. I certify that I attended the deceased from</b> <u>August 9</u> , 19 <u>61</u> , <b>to</b> <u>September 22</u> , 19 <u>61</u> , <b>that I last saw the deceased alive on</b> <u>September 22</u> , 19 <u>61</u> , <b>and that death occurred at</b> <u>5:00 PM</u> , <b>from the causes and on the date stated above.</b><br><b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b><br><b>The Clinical Center 9/22/61</b><br><b>National Institutes of Health</b><br><b>Bethesda 14, Maryland</b>   |  |  |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>J. Kent Trinkle</u> M.D.<br><b>PHYSICIAN'S NAME (Type)</b> <b>J. Kent Trinkle, M.D.</b>  |  |  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Bur-Transit</b>  |  | <b>22b. DATE THEREOF</b><br><b>9/23/61</b>               |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Salem Cemetery</b> |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |  | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE SEP 27 '61</b> |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur L. Kline</u>        |  |
| <b>22d. LOCATION (City, town, or county)</b> (State)<br><b>Winston Salem, N. Carolina</b>   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

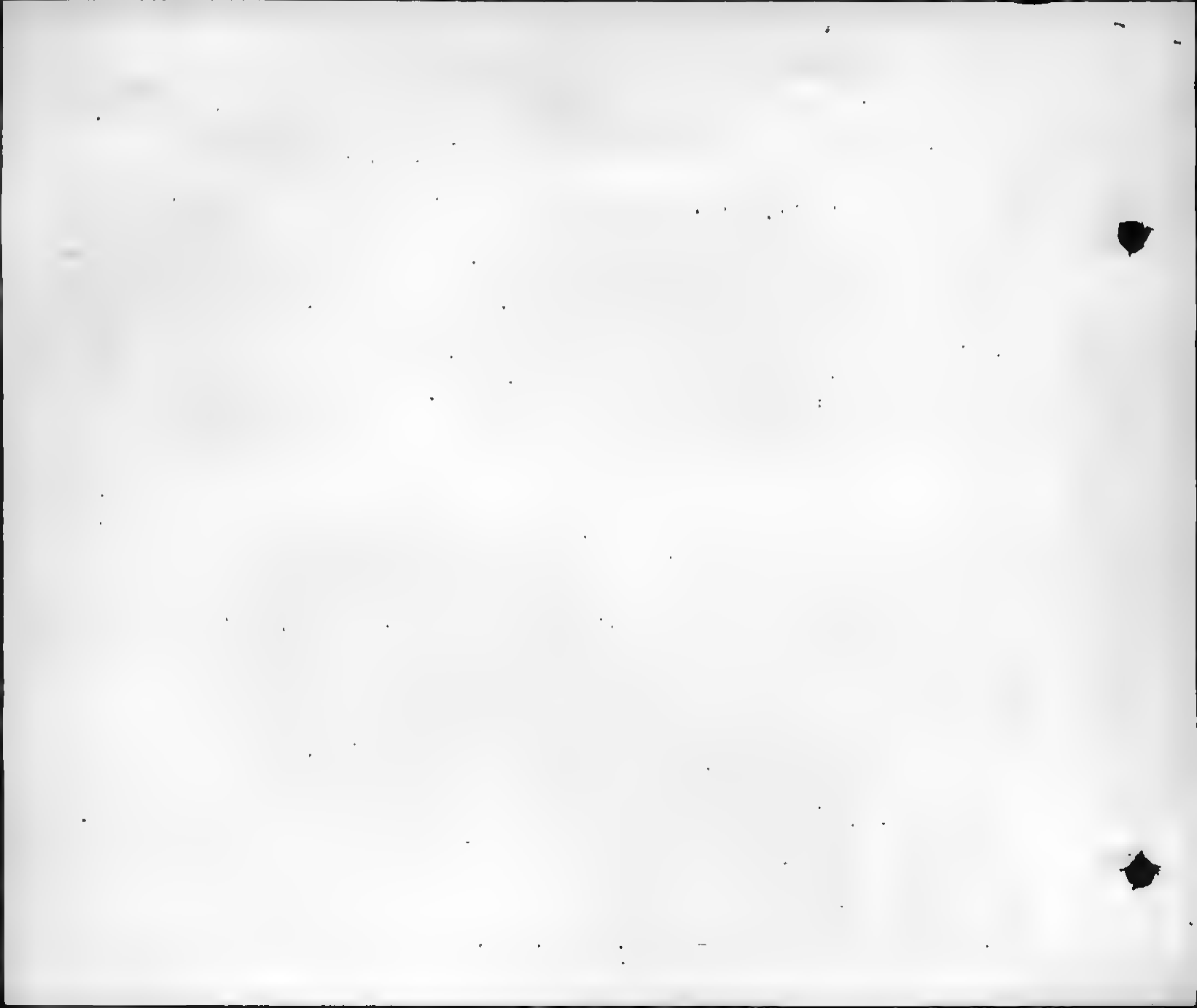
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|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>210 E. Montgomery Ave</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Beulah D. Carter</u>  |                                  | 4. DATE OF DEATH <u>September 21, 1961</u>   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 30, 1906</u>                                  |
| 9. AGE (In years, lost birthday) <u>55</u> yrs.  |                                  | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn.</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>J. C. Waddell</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Chrocia Mayes</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO. <u>220-34-7831</u>   |  |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br><u>OSIX</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Streptococcus sore throat</u><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>5 days</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced pulmonary tuberculosis-bilateral thoracoplasty</u>   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>   |  |
| 20c. TIME OF INJURY Month. Day. Year<br>Hour o. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Oct. 25, 1954</u> , to <u>September 21, 1961</u> , that I last saw the deceased alive on <u>September 24, 1961</u> , and that death occurred at <u>4:10 AM</u> , from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <u>Stephen C. Cromwell</u> M.D.   |                                  | ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave</u> DATE SIGNED <u>9/21/61</u>  |  |
| PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>   |                                  | <u>Rockville, Md.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>9/24/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Derwood</u>  | 22d. LOCATION (City, town, or county) (State) <u>Derwood, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Heeler Funeral Home-1331 E. Montg. Ave.</u>  |                                  | 24a. REC'D BY REGISTRAR <u>SEP 25 '61</u> DATE   |  |
|  |                                  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.





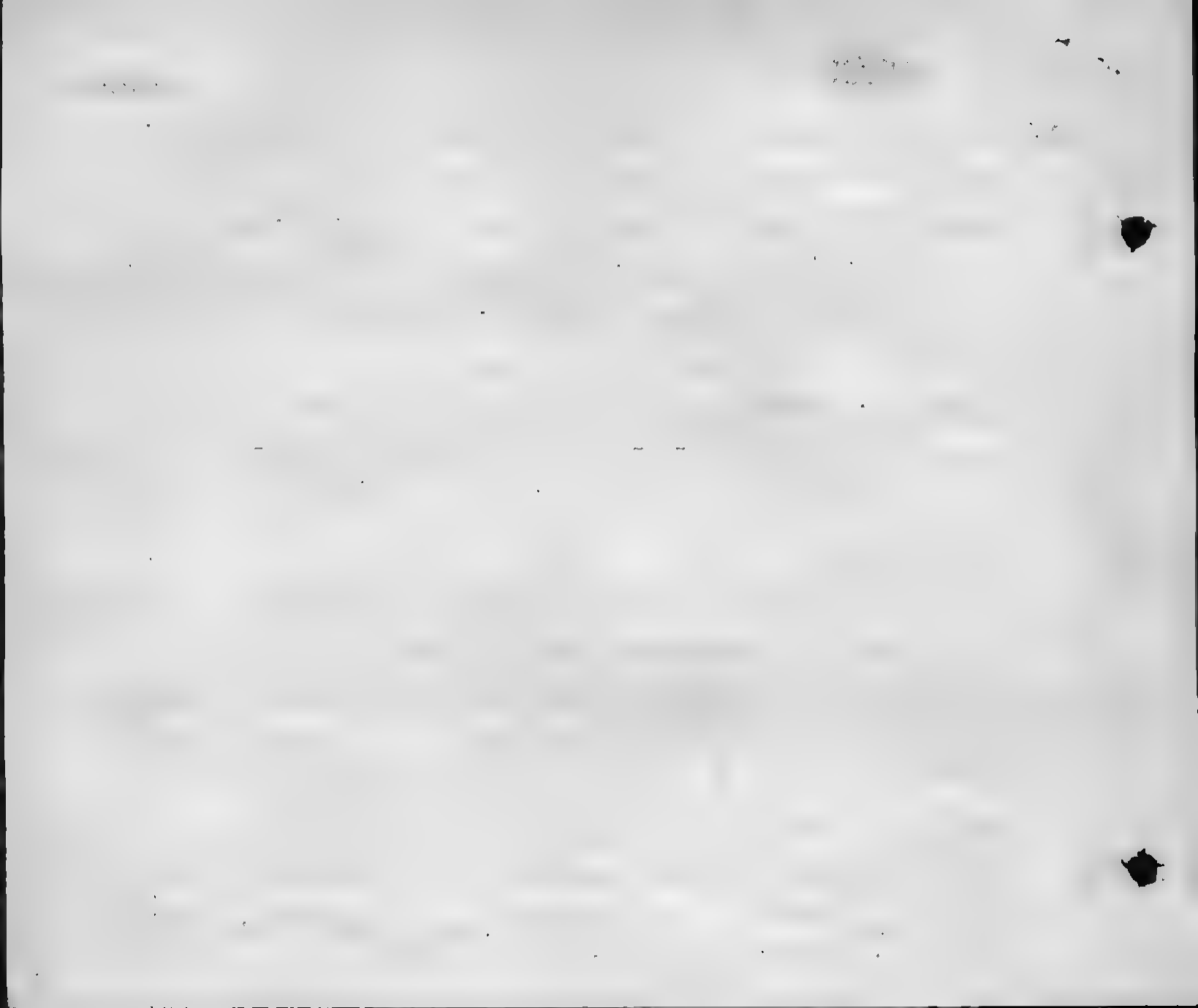
10335

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VS. A15ME  
5M 9/60

**TO LOCALITY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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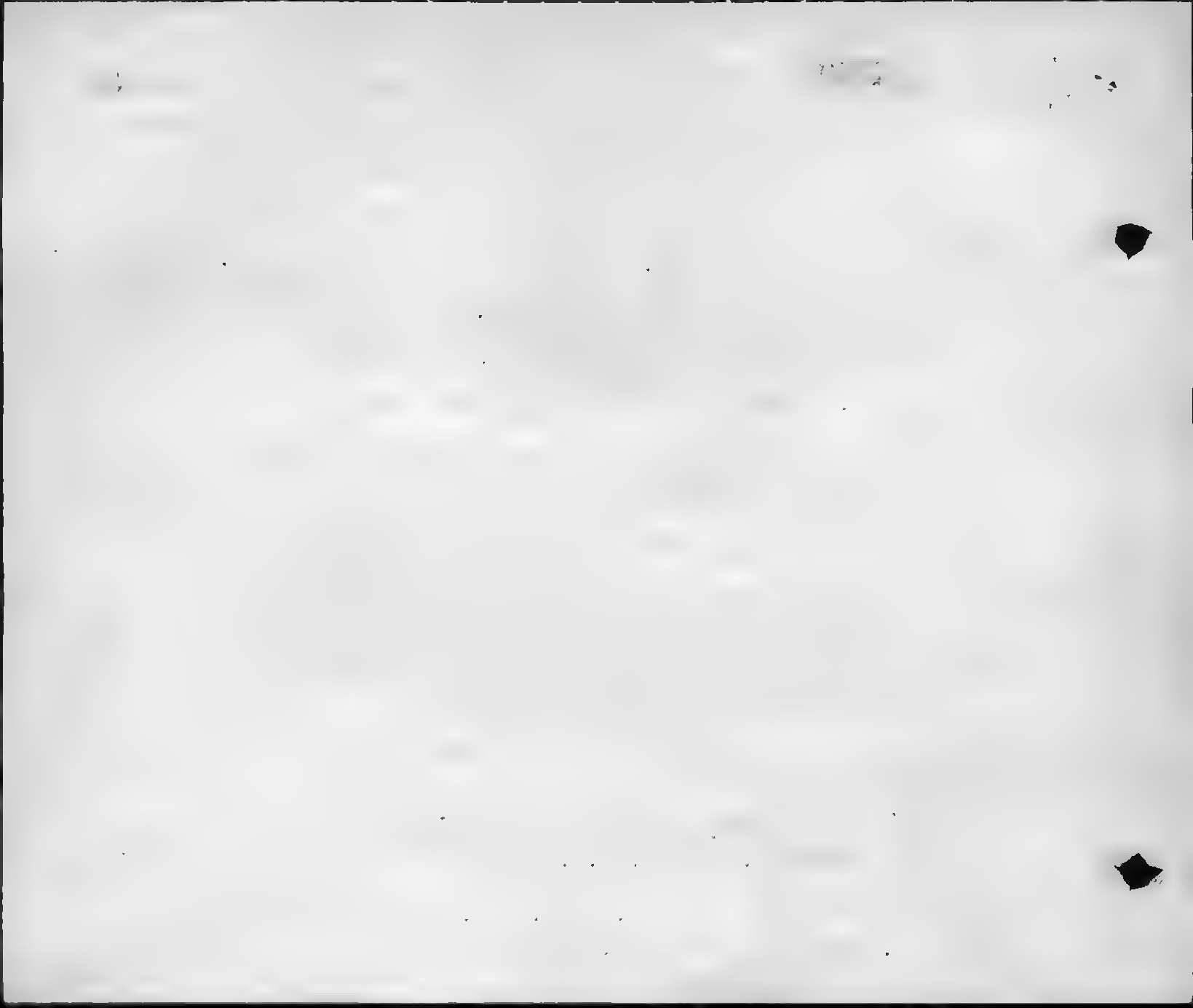
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X

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |
| 10336  |  |  |  |  | 10331   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>4845 Crescent Street</u>  |  |  |  |  | d. STREET ADDRESS<br><u>4845 Crescent Street</u>  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>EMMA</u> <u>K.</u> <u>CASTERLINE</u>   |  |  |  |  | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>5</u> Year <u>1961</u>  |  |  |  |  |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u>   |  |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH<br><u>Oct. 18, 1866</u>                           |  |  |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. AGE (in years last birthday) <u>94</u> yrs. <u>10</u> months <u>17</u> days  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>   |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pennsylvania</u>   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Burton A. Jones</u>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Balck</u>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |  |  |  | 16. SOCIAL SECURITY NO. <u>None</u>   |  |  |  |  |
| 17. INFORMANT<br><u>Edna Casterline-Daughter-same 2d</u>   |  |  |  |  | Address _____   |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br><u>4-30-0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arterio sclerosis</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</u> |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                     |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |  |  |  |
| 21. I certify that (1) (this hospital) attended the deceased from <u>September 4, 1961</u> to <u>Sept. 5, 1961</u> , that (2) (we) last saw the deceased alive on <u>September 5, 1961</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.  |  |  |  |  |   |  |  |  |  |
| 22a. SIGNATURE<br><u>Elaine W. Murphy</u>  |  |  |  |  | 22b. DATE SIGNED<br><u>9-6-61</u>   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Elaine W. Murphy, M.D.</u>  |  |  |  |  | 22d. ADDRESS<br><u>4812 Ellicott St. NW, Washington, D.C.</u>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Bur-Transit</u>  |  |  |  |  | 23b. DATE THEREOF<br><u>9/9/61</u>  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Alleg. City. Mem. Park</u>  |  |  |  |  | 23d. LOCATION (City, town or county) <u>Crafton, Penna.</u> (State) _____   |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>  |  |  |  |  | 25a. REGISTERED BY REGISTRAR<br><u>SEP 7 1961</u>   |  |  |  |  |
| ADDRESS<br><u>Bethesda, Maryland</u>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thomas</u>   |  |  |  |  |
| DATE _____   |  |  |  |  | DATE _____  |  |  |  |  |

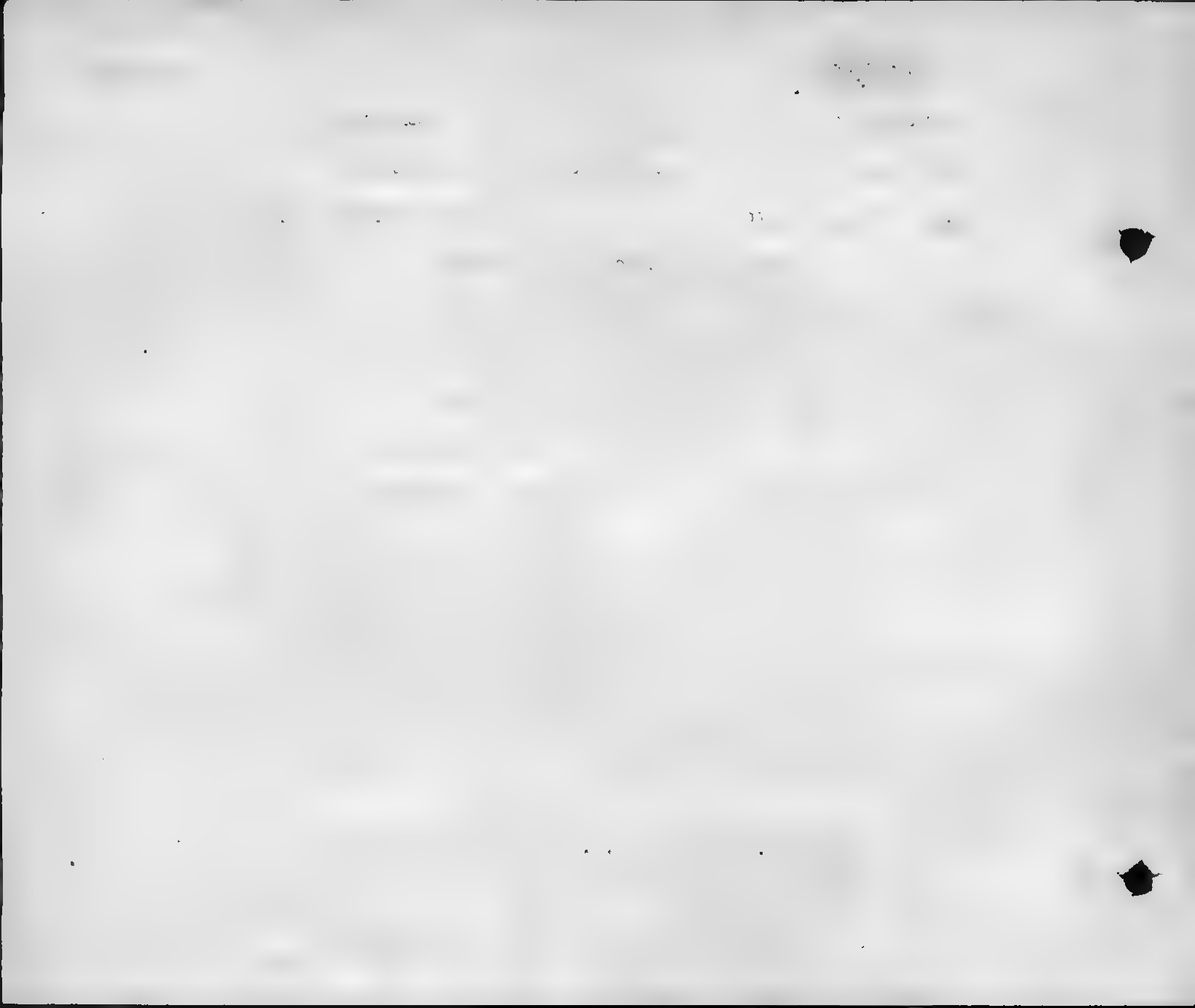
VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |  |  |  |  |
| 10337   |  |  |  |  | 10332  |  |  |  |  |
| 1. PLACE OF DEATH   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)                  |  |  |  |  |
| a. COUNTY <b>Montgomery</b>   |  |  |  |  | a. STATE <b>California</b>   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |  |  |  |  | b. COUNTY <b>Colton</b>  |  |  |  |  |
| c. LENGTH OF STAY IN <b>164 Days</b>  |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colton</b>         |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center</b>   |  |  |  |  | d. STREET ADDRESS <b>960 South 5th Street</b>  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |  |  |  | 4. DATE OF DEATH   |  |  |  |  |
| First <b>Rachel</b> Middle <b>(none)</b> Last <b>Castro</b>   |  |  |  |  | Month <b>September</b> Day <b>26</b> Year <b>19 61</b>   |  |  |  |  |
| 5. SEX <b>Female</b>  |  |  |  |  | 6. COLOR OR RACE <b>White</b>  |  |  |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 8. DATE OF BIRTH <b>February 7, 1938</b>   |  |  |  |  |
| 9. AGE (In years last birthday) <b>23 yrs.</b>  |  |  |  |  | IF UNDER 1 YEAR <b>23</b> Months Days Hours M.n.   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |  |  |  |  |
| 11. BIRTHPLACE (Country & State, or foreign country) <b>California</b>  |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |  |  |  |  |
| 13. FATHER'S NAME <b>Joseph Avarado</b>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |  |  |  | 16. SOCIAL SECURITY NO. <b>Unascertainable</b>   |  |  |  |  |
| 17. INFORMANT <b>The Medical Records</b>  |  |  |  |  | Address <b>The Clinical Center, Bethesda 14, Maryland</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>9 Months</b>   |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Choriocarcinoma</b>  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>173X</b>  |  |  |  |  |  |  |  |  |  |
| DUE TO (c)  |  |  |  |  |  |  |  |  |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)             |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b>  |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |  |
| 21. I certify that <b>30</b> (this hospital) attended the deceased from <b>April 15, 1961</b> to <b>September 26, 1961</b> , that <b>31</b> (we) last saw the deceased alive on <b>September 26, 1961</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above. |  |  |  |  |  |  |  |  |  |
| 22. SIGNATURE <b>Stanley G. Korenman</b> M.D.   |  |  |  |  | 22b. DATE SIGNED <b>9-26-61</b>  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Stanley G. Korenman</b>   |  |  |  |  | 22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>               |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP A-R</b>   |  |  |  |  | 23b. DATE THEREOF <b>9-27-61</b>   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Wash D.C. 1400 Chapin St N.W.</b>   |  |  |  |  | 23d. LOCATION (City, town or county) (State) <b>COLTON CALIF</b>                                       |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>   |  |  |  |  | 25. REC'D BY REGISTRAR <b>SEP 29 '61</b>   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |  |  |  |  |  |  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10338

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10338

FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                               |  |                                |
|---|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u>                       |                                |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                               | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |                                |
| c. LENGTH OF STAY IN TB <u>12 hr</u>  |                               | d. STREET ADDRESS <u>5818 Handgrip Ave</u>   |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |
| 3. NAME OF DECEASED (Type or print) <u>Donald William Catron</u>  |                               | 4. DATE OF DEATH <u>Sept 3 1961</u>  |                                |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-5-60</u> |
| 9. AGE (In years last birthday) <u>1</u> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>   |                                |
| 11. BIRTHPLACE (State or foreign country) <u>md</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                |
| 13. FATHER'S NAME <u>Harvey J. Catron</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Sylvia Lancaster</u>   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO. <u>-</u>   |                                |
| 17. INFORMANT <u>Hoyle Reemel</u>   |                               | Address  |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock</u><br>413.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage &amp; pulmonary edema</u><br>DUE TO (c) <u>Laceration Rt jugular vein</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>INTERVAL BETWEEN ONSET AND DEATH <u>12 3/4 hr</u> |                               |  |                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall on broken glass bowl</u>                            |                                |
| 20c. TIME OF INJURY Month, Day, Year <u>12:15 p.m. 9-2 1961</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>  |                               | 20f. (City or town) <u>Rockville</u> (County) <u>montg</u> (State) <u>md</u>   |                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                               |  |                                |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.   |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>9/5/61</u>  |                                |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Churchlawn</u>   |                               | 22d. LOCATION (City, town, or country) (State) <u>Clarksburg, Md.</u>  |                                |
| 23. FUNERAL DIRECTOR <u>Lyons Wheeler - Rockville, Md.</u>  |                               | 24a. REC'D BY REGISTRAR <u>Sept 7 '61</u>  |                                |
| 24b. REGISTRAR'S SIGNATURE <u>Clifford S. House</u>   |                               | DATE SIGNED <u>9-3-61</u>  |                                |

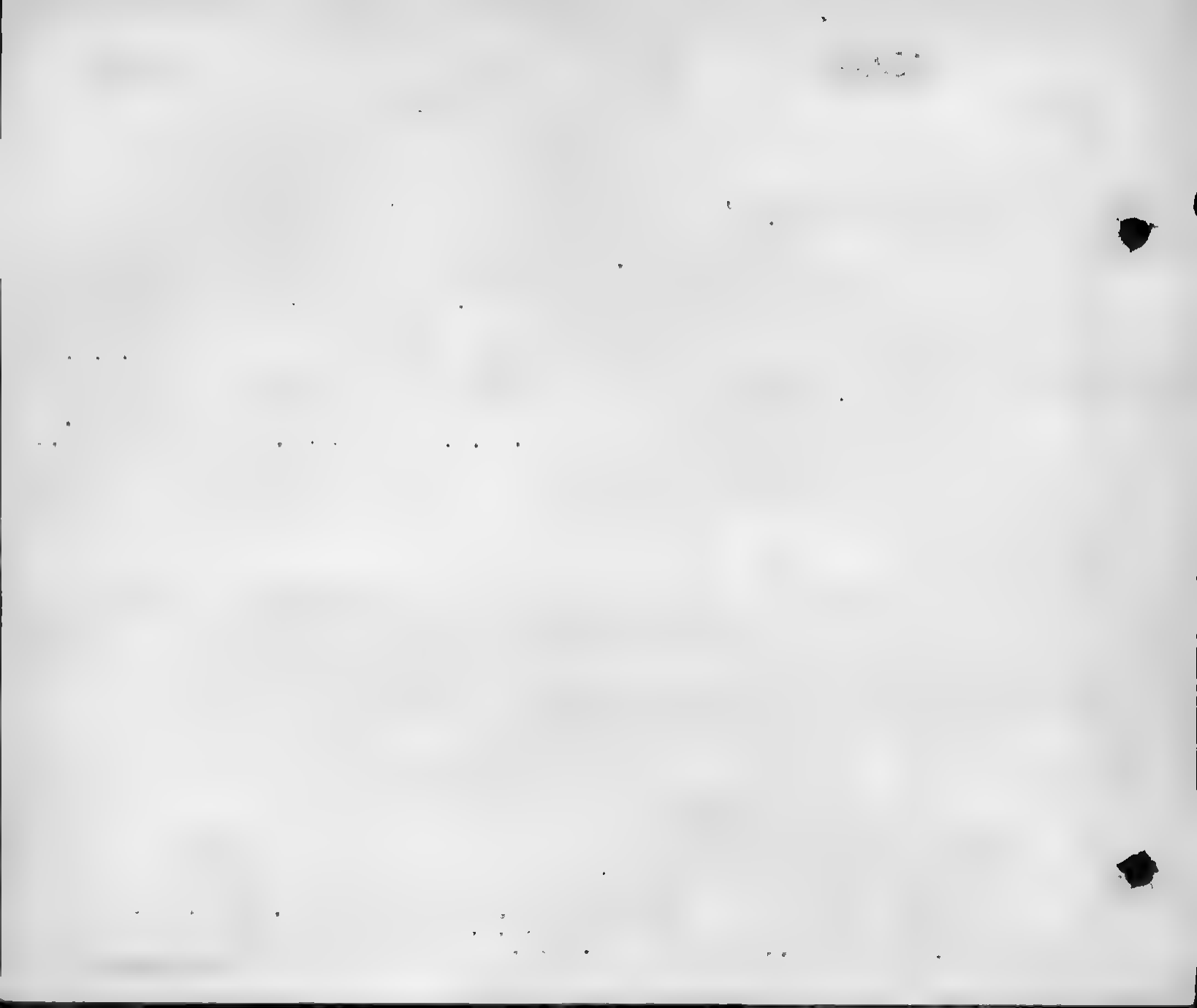




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                    |  |  |  |   |  |   |  |  |  |
|--|--|------------------------------------|--|--|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                    |  |  |  |   |  |   |  |  |  |
| 10339  |  |                                    |  |  |  | 10334   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |                                    |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |  |                                    |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Alexandria</u>   |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Bel Pre Nursing Home, 2525 Bel Pre Rd.,</u>   |  |                                    |  |  |  | d. STREET ADDRESS<br><u>906 Allison Street</u>  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ethel</u> Middle <u>S.</u> Last <u>Chaffin</u>   |  |                                    |  |  |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>1</u> Year <u>1961</u>  |  |   |  |  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec 28, 1887</u>   |  | 9. AGE (In years last birthday)<br><u>73</u> yrs. |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Oklahoma</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |  | 13. FATHER'S NAME<br><u>Christian F. Sommer</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Barbara Ellen Hughes</u>              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)  |  |                                    |  |  |  | 17. INFORMANT<br>Address <u>Alex, Va.</u><br><u>Col. A.D. Chaffin, Jr. 906 Allison St.,</u>   |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>+20.0 Congestive Heart Failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |                                    |  |  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u><br><u>5 years</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                    |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. <u>  </u> p.m. <u>  </u>  |  | Month, Day, Year<br><u>19</u>      |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><u>  </u>                  |  | (County) <u>  </u> (State) <u>  </u>                                 |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1961</u> to <u>9/1</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>9/1</u> , 19 <u>61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.  |  |                                    |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Max G. Sheper</u> M.D.  |  |                                    |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |  | 22b. DATE SIGNED<br><u>9/1/61</u>                 |  | 22c. PHYSICIAN'S NAME (Type)<br><u>MAX G. SHERER, M.D.</u>           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>   |  | 23b. DATE THEREOF<br><u>9/6/61</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington Nat. Cemetery</u>   |  | 23d. LOCATION (City, town or county)<br><u>Ft. Myer, Va.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>SEP 5 '61</u>       |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur J. Hines</u>                 |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>The S.H. Hines Co., 2901 14th St. N.W.</u>  |  |                                    |  |  |  | 25a. REC'D BY REGISTRAR<br><u>SEP 5 '61</u>   |  |   |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

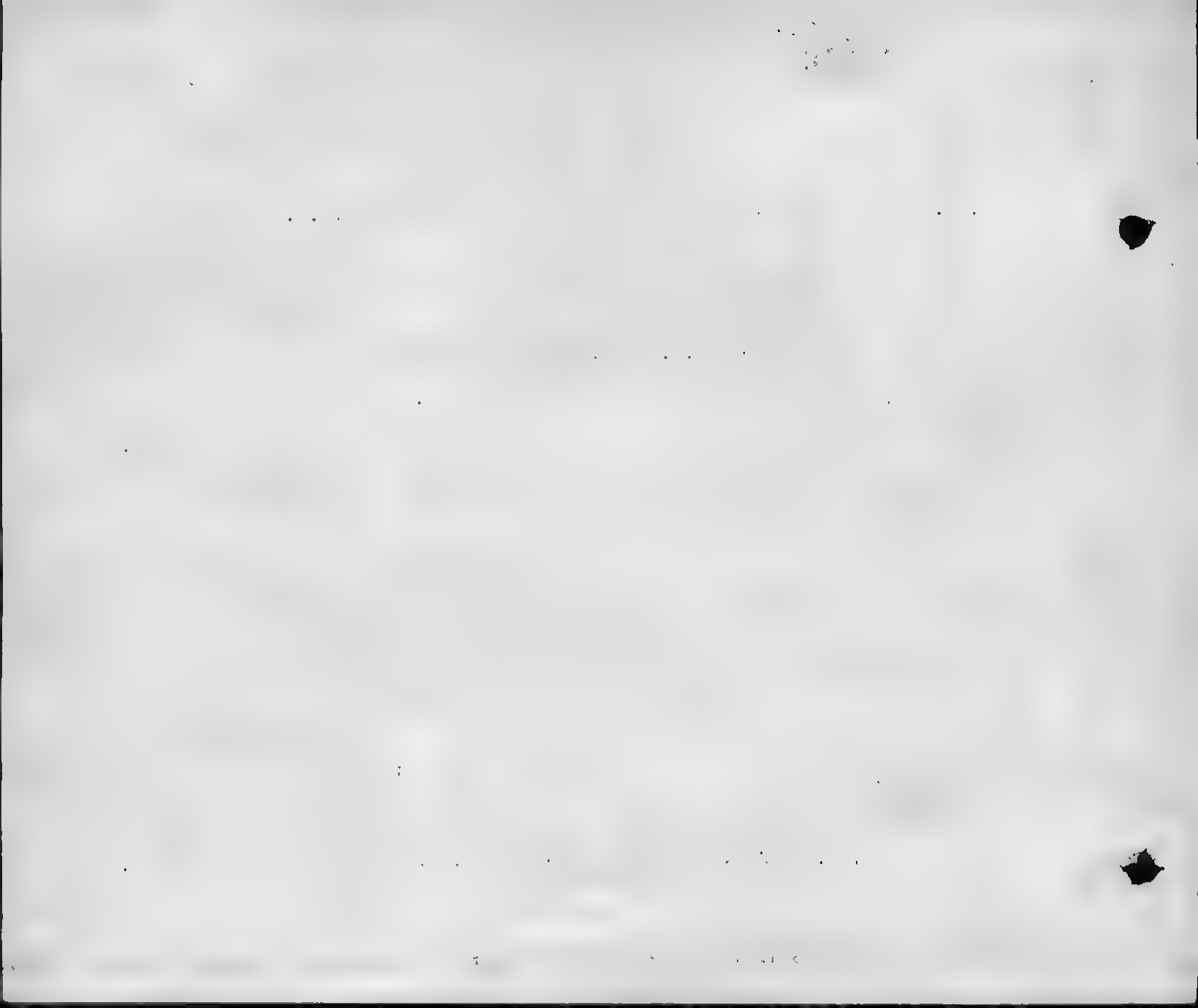
10340

## CERTIFICATE OF DEATH

10335

|  |  |  |   |
|--|--|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN 1b <u>27 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>                                |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission)<br>a. STATE <u>Washington</u><br>b. COUNTY <u>Seattle</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>6839 34th Ave. N.E.</u><br>d. STREET ADDRESS <u>6839 34th Ave. N.E.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Rita Marie Chambers</u>   |  | <b>4. DATE OF DEATH</b><br><u>September 19 19 61</u>   |   |
| <b>5. SEX</b><br><u>Female</u>   | <b>6. COLOR OR RACE</b><br><u>Caucasian</u>  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><u>6-27-21</u>                                       |
| <b>9. AGE</b> (In years last birthday) <u>40 yrs.</u>  |  | <b>10. AGE</b> (In years last birthday) <u>40 yrs.</u>   |   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Foreign Service Officer</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Government</u>  |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Nebraska</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>  |   |
| <b>13. FATHER'S NAME</b><br><u>Arthur W. Chambers</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Ava T. Williams</u>  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>Doris Chambers (Sister) Same as #2 above</u>   |   |
| <b>17. INFORMANT</b><br><u>Doris Chambers (Sister) Same as #2 above</u>  |  | <b>18. CRUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>ANEURYSM, RT. ANTERIOR CEREBRAL ART.</u><br>(b) <u>CONGENITAL</u><br>(c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>  |   |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)   |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m.<br>p.m.  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  | <b>20f. (City or town)</b> (County) (State)                                     |
| <b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 23, 1961</u> to <u>September 19, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept 19, 1961</u> and that death occurred at <u>5:55 A.M.</u> from the causes and on the date stated above. |  |  |   |
| <b>22a. SIGNATURE</b><br><u>R. W. Mackie</u>   |  | <b>22b. DATE SIGNED</b><br><u>20 Sept 1961</u>   |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>R. W. MACKIE, CAPTAIN, MC, USN</u>  |  | <b>22d. ADDRESS</b><br><u>U. S. Naval Hospital, Bethesda, Md.</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial-Shipment</u>   | <b>23b. DATE THEREOF</b><br><u>9-21-61</u>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>St. Joseph Cemetery</u>  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Atkinson Nebraska</u> |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Robert A. Pumphrey</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 22 '61</u>  |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles L. Kline</u>   |  | <b>25c. REGISTRAR'S SIGNATURE</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 10336

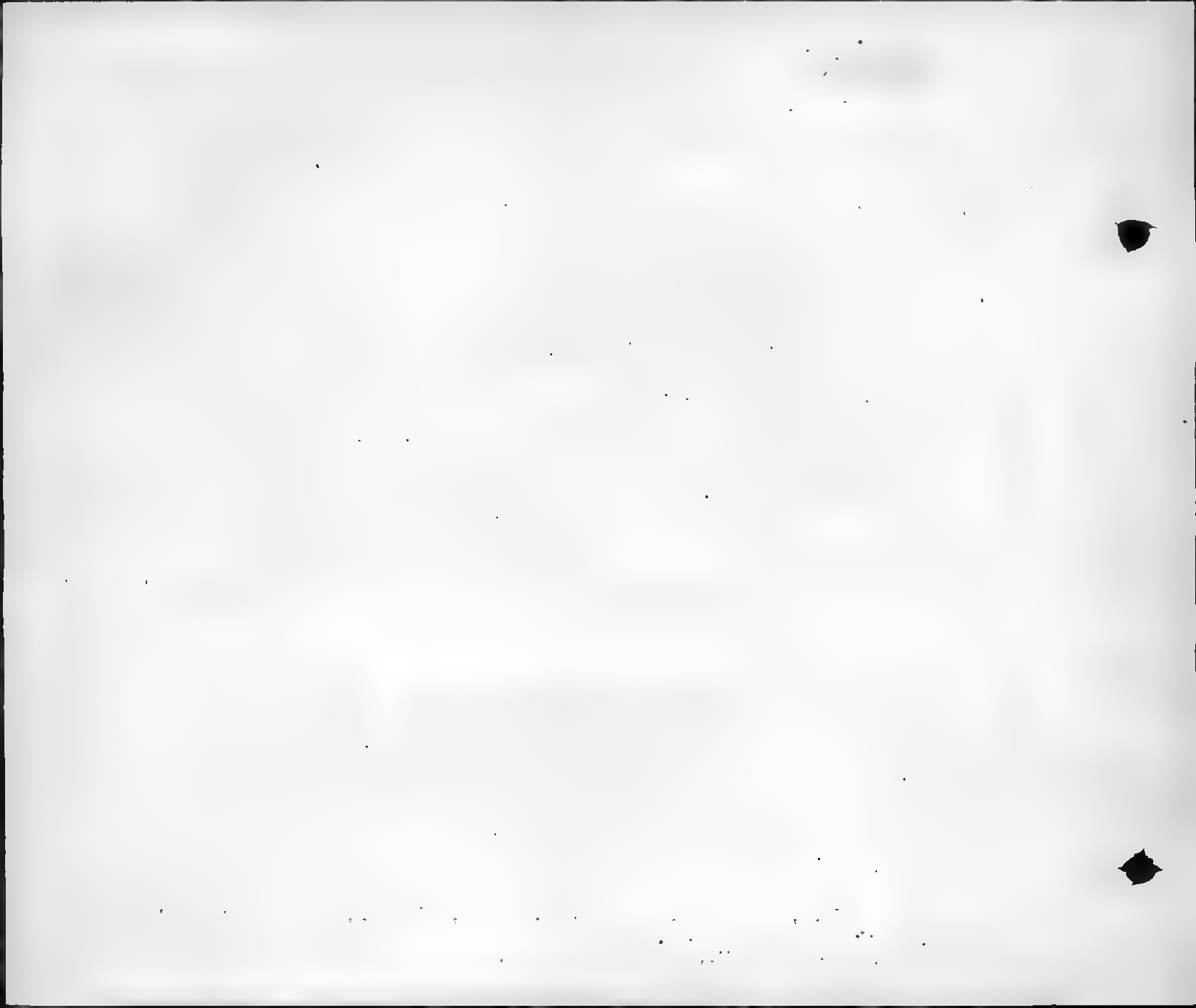
|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9914 CAPITOL VIEW AVENUE</u>   |  | d. STREET ADDRESS <u>9914 CAPITOL VIEW AVE.</u>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ROLAND DEANE CHAPMAN</u>  |  | 4. DATE OF DEATH Month Day Year <u>SEPT 30 1961</u>  |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 10, 1881</u>   |
| 9. AGE (In years last birthday) <u>80 yrs.</u>   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER retired</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING (owner)</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>OHIO</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>GEORGE CHAPMAN</u>  |  | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH MCCARTY</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO <u>297-24-1588A</u>   |  |
| 17. INFORMANT <u>MR. RAYMOND CHAPMAN</u>   |  | Address <u>ABOVE.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u><br><u>260X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause as:<br>(b) <u>CEREBRAL ATHEROSCLEROSIS</u><br>DUE TO<br>(c) <u>DIABETES MELLITUS</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 YEARS</u><br><u>2 YEARS</u><br><u>12 YEARS</u>        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>JAN 8</u> , 19 <u>59</u> , to <u>SEPT. 30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>SEPT. 30</u> , 19 <u>61</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVE.</u>   |  | DATE SIGNED <u>9/30/61</u>   |  |
| PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>  |  | <u>SILVER SPRING, MD.</u>  |  |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 22b. DATE THEREOF <u>OCT. 3, 1961</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>BEECH GROVE CEMETERY, POMEROY, MEIGS COUNTY, OHIO</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>  |  | 24a. REC'D BY REGISTRAR <u>DATE OCT 3 '61</u>  | 24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>   |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10337

FOR STATE HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Burtonsville

c. LENGTH OF STAY (in days)

7 mo

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

14221 Green Castle Rd

### 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

MD

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

14221 Green Castle Rd

d. STREET ADDRESS

14221 Green Castle Rd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

5. SEX

male

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8-17-1885

9. AGE (in years last birthday)

76 yrs

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Butcher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Custria

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Cholwak

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

John S. Cholwak (son) Item 2

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.1

DUE TO

Coronary occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Arteriosclerosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden

minutes

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschert

M.D.

CHIEF MEDICAL EXAMINER ☐

ASS. STANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9-13-61

EXAMINER'S NAME (Type)

FRANK J. Broschert

Address Street city town or county

22a. BURIAL, CREMATION

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City town, or country)

(State)

22a. BURIAL, CREMATION

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City town, or country)

(State)

23. FUNERAL DIRECTOR

9-13-1961

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City town, or country)

(State)

Robert A. Mattingly

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City town, or country)

(State)

131-111111 Wash DC

22d. LOCATION (City town, or country)

(State)

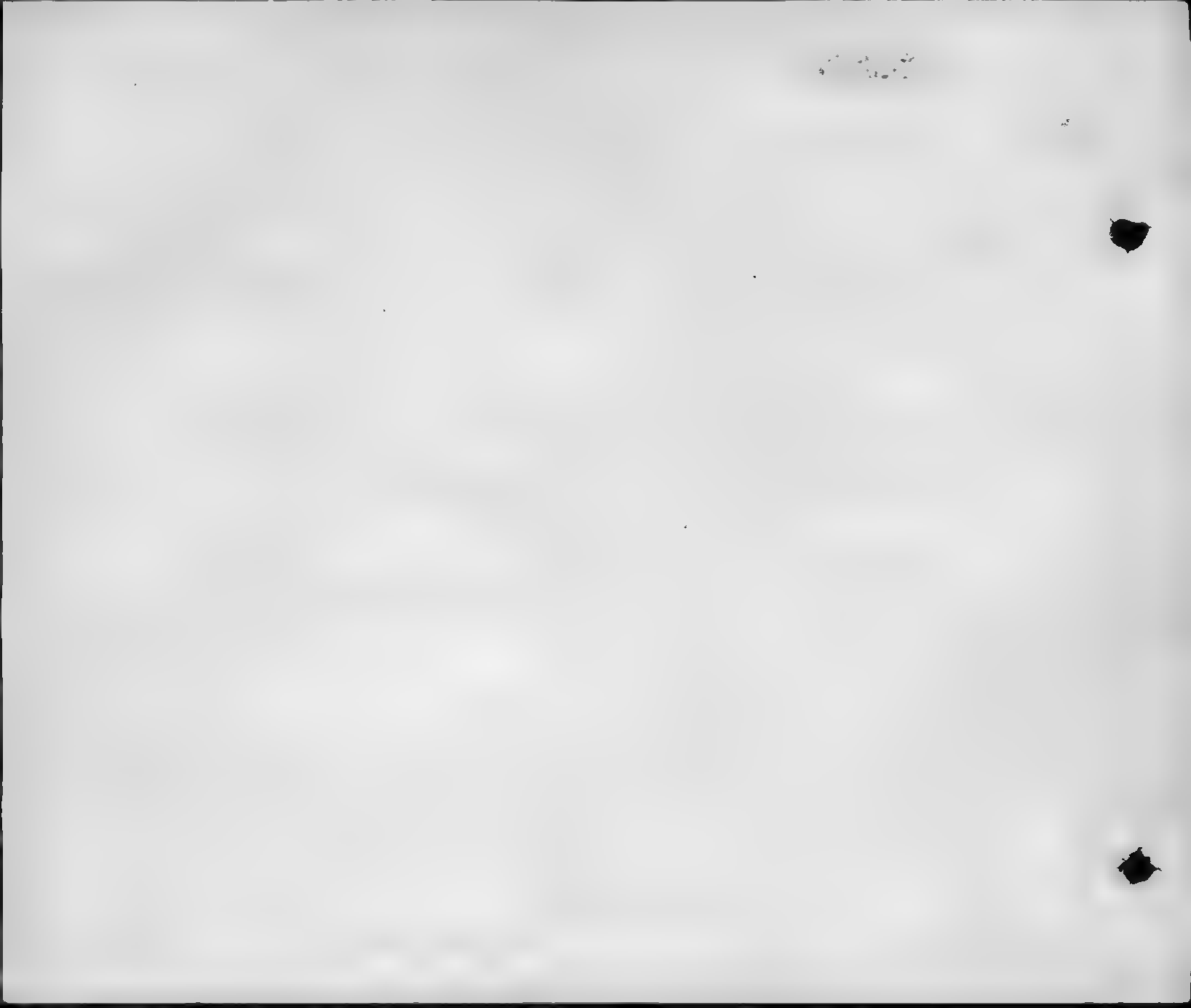
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE SEP 18 1961

SEP 18 1961

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





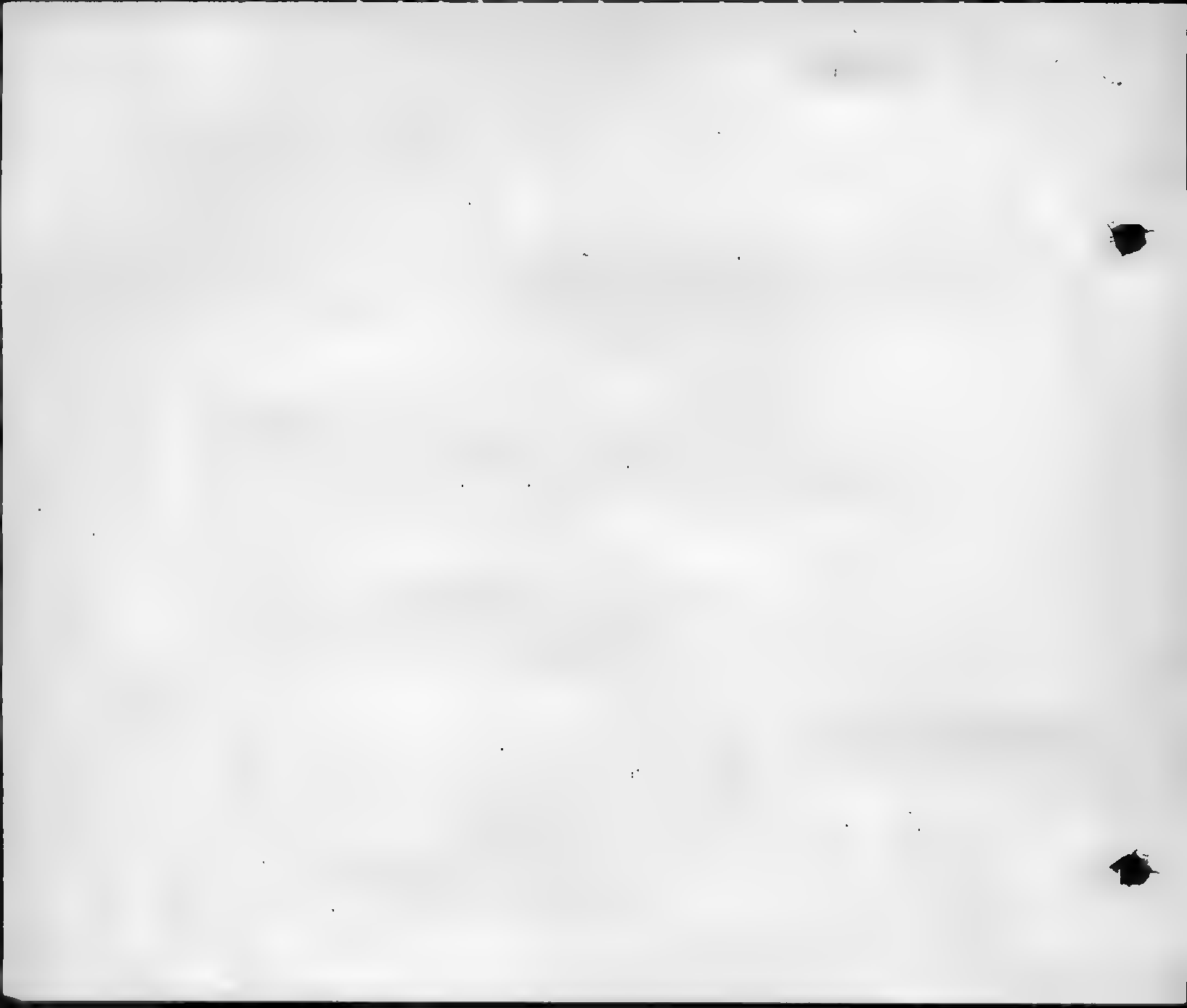
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

10343

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived) If institution Residence other than (State)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>   |                                  | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Bethesda</i>  |   |
| c. LENGTH OF STAY IN 1b <i>7 yrs 6 mos</i>   |                                  | d. STREET ADDRESS <i>5525 Charles Street</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><i>Elizabeth Bertha Clinton</i>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><i>Sept 28 1961</i>  |   |
| 5. SEX <i>F</i>  | 6. COLOR OR RACE <i>W</i>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb. 11 1869</i>                                    |
| 9. AGE (In years last birthday) <i>92</i> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School teacher</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Teaching</i>  |   |
| 11. BIRTHPLACE (State or foreign country) <i>N. J.</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <i>yes</i>  |   |
| 13. FATHER'S NAME <i>Charles Clinton</i>   |                                  | 14. MOTHER'S MAIDEN NAME <i>Frances Ireland</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>  |                                  | 16. SOCIAL SECURITY NO <i>None</i>   |   |
| 17. INFORMANT <i>Mrs. John Dickinson</i>   |                                  | Address <i>5525 Charles St. Bethesda, Md.</i>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral arterial bleeding</i><br><i>450.0</i> DUE TO (b) <i>Uremia</i><br>Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>arteriosclerosis</i> |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>5 days</i><br>INTERVAL BETWEEN ONSET AND DEATH (b) <i>Uuh</i><br>(c) <i>Uuh</i>   |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept 23 1961</i> to <i>Sept 28 1961</i> , that (I) (we) last saw the deceased alive on <i>Sept 28 1961</i> , and that death occurred at <i>3:45 PM</i> from the causes and on the date stated above.  |                                  |  |   |
| 22a. SIGNATURE <i>George Sharpe MD</i>   |                                  | 22b. DATE SIGNED <i>9/28/61</i>  |   |
| 22c. PHYSICIAN'S NAME (Type) <i>George Sharpe</i>  |                                  | 22d. ADDRESS <i>10511 Summit Ave. Kensington, Md.</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>   | 23b. DATE THEREOF <i>9/30/61</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>   | 23d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>   |                                  | ADDRESS <i>Bethesda, Maryland</i>  |   |
| 25a. REC'D BY REGISTRAR <i>SEP 29 '61</i>  |                                  | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10344

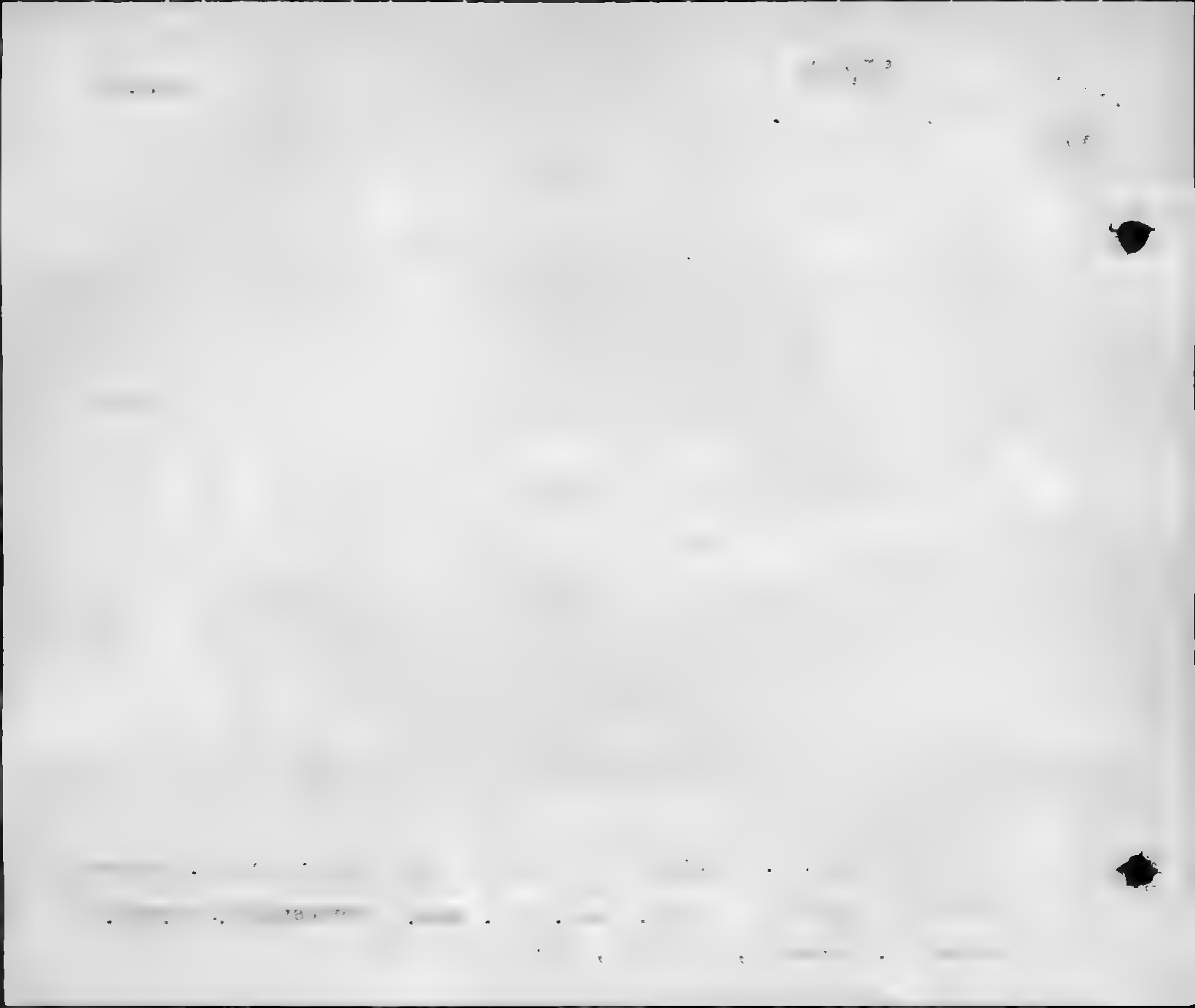
10339

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution, give name and address)<br>a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>                      |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bensington</u>  |  |
| c. LENGTH OF STAY IN 1b<br><u>1 day thro.</u>  |   | d. STREET ADDRESS<br><u>10209 - Montgomery Ave</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>John Stanley Coffin</u>   |   | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>21</u> Year <u>1961</u>  |  |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12/23/48</u>  |
| 9. AGE (in years last birthday)<br><u>13</u> yrs.  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Child</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>md.</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>U.S.A.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>John Coffin</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Miriam Coffin Hilton</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  |
| 17. INFORMANT<br><u>Dr. Chart</u>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u><br>260 X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>ACIDOSIS, DEHYDRATION</u><br>(a), stating the underlying cause last. DUE TO (c) <u>DIABETES MELLITUS</u>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hrs.</u><br><u>96 hrs.</u><br><u>6 wks.?</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> ....., 19 <u>61</u> , to <u>9-21</u> ....., 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9-21</u> ....., 19 <u>61</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above. |   |  |  |
| 22a. SIGNATURE<br><u>John E. Cassidy</u>   |   | 22b. DATE SIGNED<br><u>9-21-61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John E. Cassidy</u>   |   | 22d. ADDRESS<br><u>9911 Old Georgetown Rd. Bethesda Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>9/25/61</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Geo. Wash. Mem. Cem.</u>  | 23d. LOCATION (City, town or county) (State)<br><u>Hyattsville, Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey, Bethesda, Maryland</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 27 1961</u>   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur P. Knapp</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 5 and 6 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

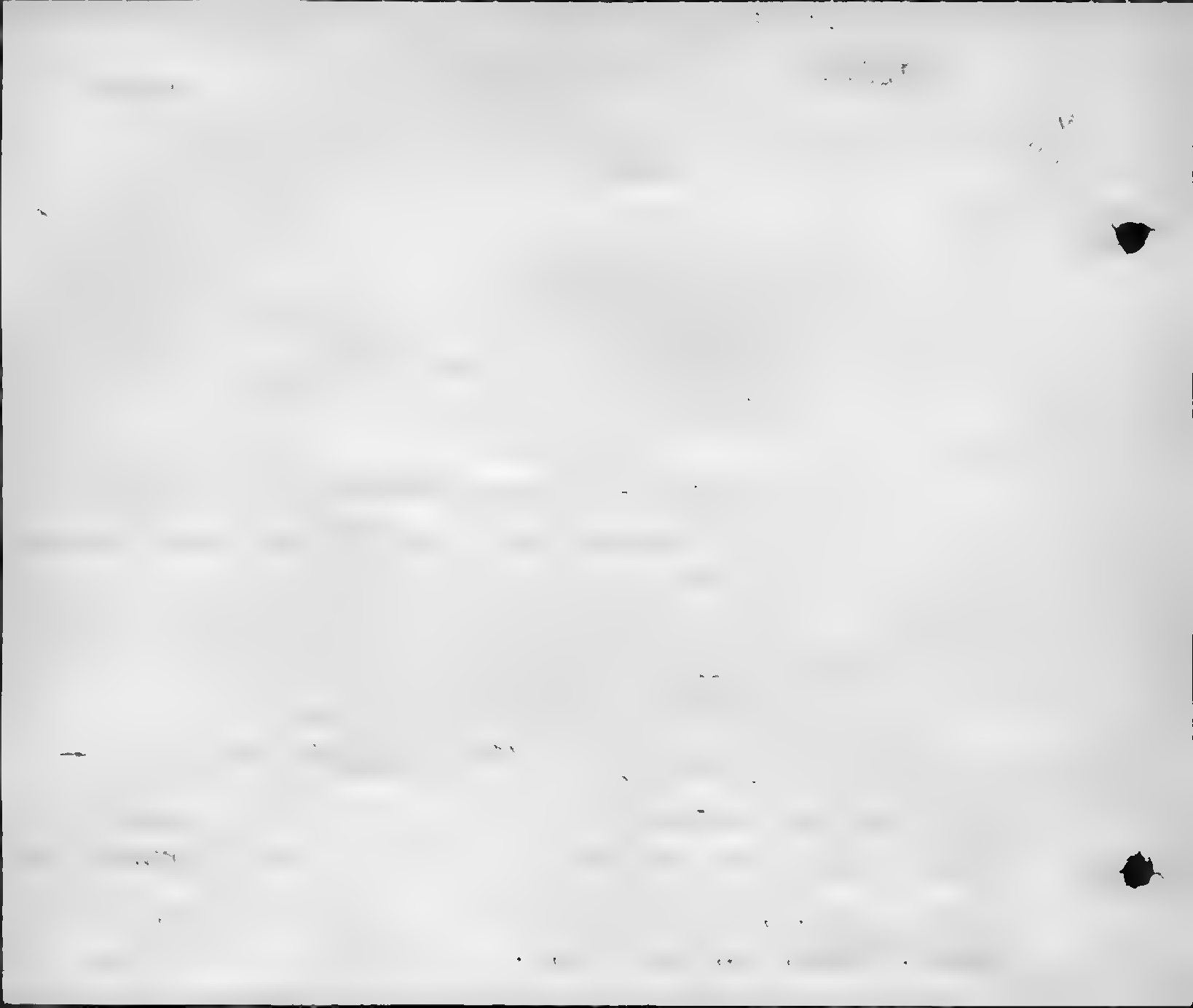
## CERTIFICATE OF DEATH

10345

10340

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u><br>c. LENGTH OF STAY IN 1b <u>1 month</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WHEATON NURSING Home</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u><br>d. STREET ADDRESS <u>1128 24 VALLEYWOOD DR.</u> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>CORDELIA ORDER COGSWELL</u>   |  | <b>4. DATE</b><br>Month <u>9</u> Day <u>21</u> Year <u>1961</u><br>DEATH   |  |
| <b>5. SEX</b> <u>F</u>   |  | <b>6. COLOR OR RACE</b> <u>W</u>   |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>9-22-1895</u>  |  |
| <b>9. AGE</b> (In years last birthday) <u>65</u> yrs.  |  | <b>10. IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>  |  |
| <b>11. IF UNDER 24 HRS</b><br>Hours <u>  </u> Min. <u>  </u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Own Home</u>  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Kentucky</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>Richard ORDER</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>MARY M. DUNAWAY</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>No</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>husband</u>   |  |
| <b>17. INFORMANT</b><br><u>husband</u>   |  | <b>18. ADDRESS</b><br><u>1st.</u>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u><br>(b) <u>157X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Cerebral of the pancreas 6 months</u><br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).<br><u>  </u> |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  |  |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)<br><u>  </u>   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>   |  | <b>20f. (City or town)</b> (County) (State)<br><u>  </u>   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May</u> <u>1961</u> , to <u>21 Sept</u> <u>1961</u> , that (I) <u>last</u> saw the deceased alive on <u>21 Sept</u> <u>1961</u> , and that death occurred <u>3:45 PM</u> on the causes and on the date stated above.   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>W. Ronald Strong MD</u>  |  | <b>22b. DATE SIGNED</b><br><u>21 Sept 61</u>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>W. Ronald STRONG MD</u>  |  | <b>22d. ADDRESS</b><br><u>1028 CONN AVE NW WASH DC</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>Sept. 23, 1961</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Parklawn Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Montgomery County, Maryland</u>  |  |
| <b>24. GENERAL DIRECTOR'S SIGNATURE</b><br><u>Raymond C. Ziska</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>SEP 25 '61</u>   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kneass</u>   |  | <b>25c. ADDRESS</b><br><u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.



## CERTIFICATE OF DEATH

Reg. Dist. No.

10346

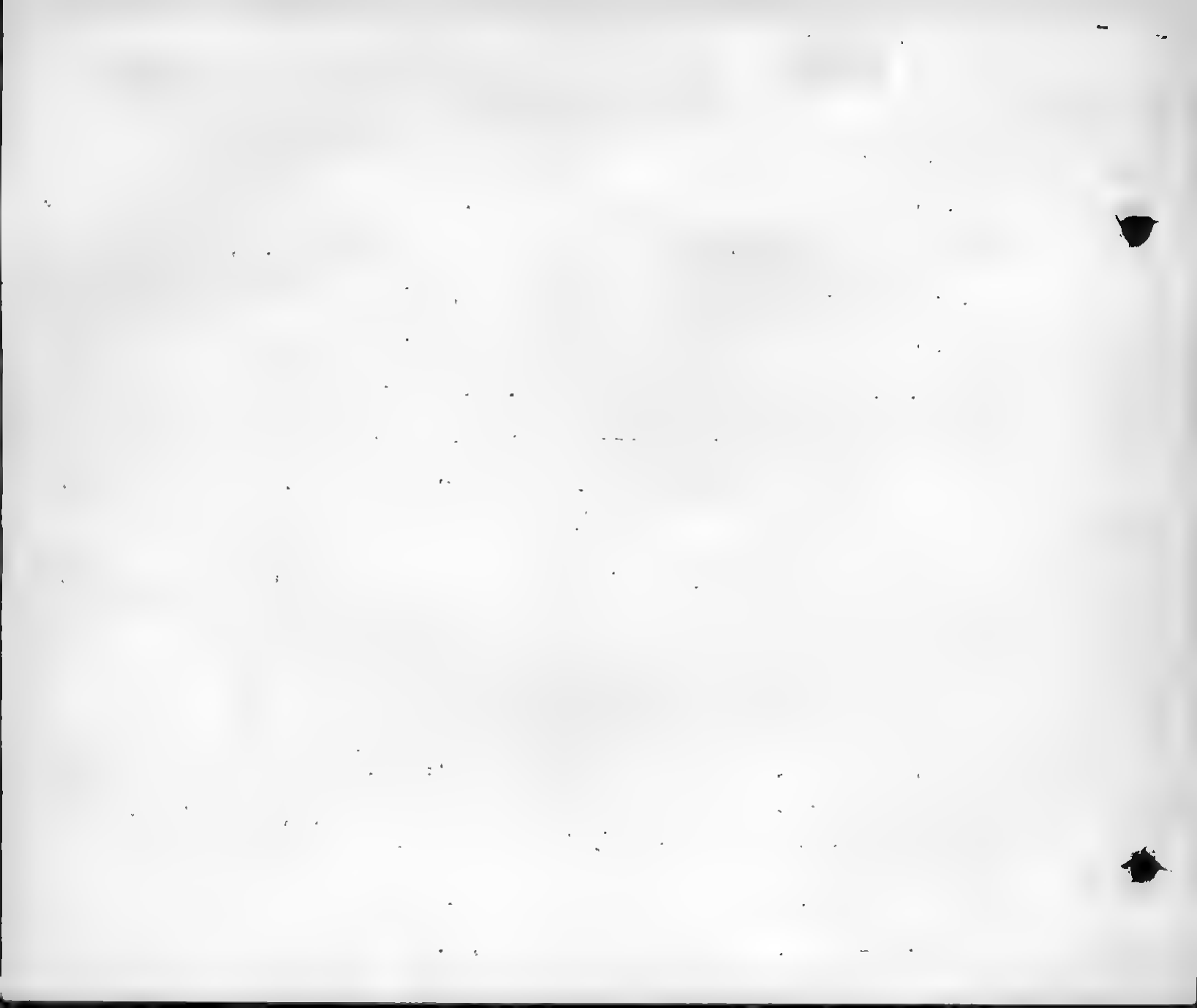
10341

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence for admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>107 S. Summit Avenue</u>  |  | d. STREET ADDRESS<br><u>107 S. Summit Avenue</u>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Charles</u> <u>MIDDLE</u> <u>COOKE</u>   |  | 4. DATE OF DEATH Sept. 4, 1961<br>Month Day Year  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 14, 1942</u>                                 |
| 9. AGE (In years last birthday)<br><u>39</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min | IF UNDER 24 HRS   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Teacher</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Harry C. Griffith</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Alverda Cooke</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO<br><u>-----</u>  |  |
| INFORMANT<br><u>Alverda C. Cooke - Item # 2</u>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Vascular-Renal Disease with Hypertension.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized Arteriosclerosis</u><br>DUE TO (c) <u>Terminal Viral Acute-Gastro-enteritis</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>20 yrs.</u><br><u>?</u><br><u>3 days.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS A JPTPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>No injury</u>  |  |
| 20c. TIME OF INJURY Month Day Year<br>Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>January, 1937</u> to <u>Sept. 4, 1961</u> , that I last saw the deceased alive on <u>September 4, 1961</u> , and that death occurred at <u>11:45 P.</u> from the causes and on the date stated above.   |  |   |  |
| ACTUAL SIGNATURE <u>M. McKendree Boyer</u>   |  | ADDRESS (Street, city or town, state) <u>M.D. 9830 Main Street, Sent. 5, 1961</u>   |  |
| PHYSICIAN'S NAME (Type) <u>M. D. Damascus, Maryland.</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>9/7/61</u>       | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Goshen Church Cemetery</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Goshen, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Phoebe-1231</u>   |  | ADDRESS   |  |
| 24a. REC'D BY REGISTRAR<br><u>SEP 7 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thomas</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10347

## CERTIFICATE OF DEATH

Reg. Dist. No.

10342

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland   |  | b. COUNTY<br>Montgomery  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring  |  | c. LENGTH OF STAY IN b<br>eight years   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring   |  | 15   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>301 Quaint Acres Drive   |  |   |  | d. STREET ADDRESS<br>301 Quaint Acres Drive   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>HELLEN ROBINSON COWELL   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br>9 28 1961   |  |  |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>White   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>June 29, 1916  |  |
| 9. AGE (In years last birthday)<br>45 yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Contract Statistician   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Self employed  |  | 11. BIRTHPLACE (State or foreign country)<br>South Dakota   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>Elmer M. Robinson   |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Edna M. Remington   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No   |  | 16. SOCIAL SECURITY NO.<br>577-36-2973  |  | 17. INFORMANT<br>Mr. Othel J. Cowell  |  |  |  |
|  |  |   |  | Address<br>301 Quaint Acres Drive<br>Silver Spring, Maryland  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 156.1 DUE TO Hypostatic Pneumonia<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Liver<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br>24 hours<br>15 months |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month. Day. Year<br>Hour a. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from 9/26, 1961, to 9/28, 1961, that I last saw the deceased alive on 9/28, 1961, and that death occurred at 11:25 AM, from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Hugh Irey  |  | M.D. 7105 - Riggs Rd.   |  | ADDRESS (Street, city or town, state)<br>HYATTSVILLE, MD.   |  | DATE SIGNED<br>9/28/61   |  |
| PHYSICIAN'S NAME (Type)<br>HUGH IREY   |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 22b. DATE THEREOF<br>9/30/61  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>George Washington   |  | 22d. LOCATION (City, town, or county) (State)<br>Prince George's County, Md.           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Walter E. Pumphrey, Inc.   |  | ADDRESS<br>8434 Georgia Avenue<br>Silver Spring, Maryland   |  | 24a. REC'D BY REGISTRAR<br>OCT 2 '61  |  | 24b. REGISTRAR'S SIGNATURE<br>Charles E. Hays  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



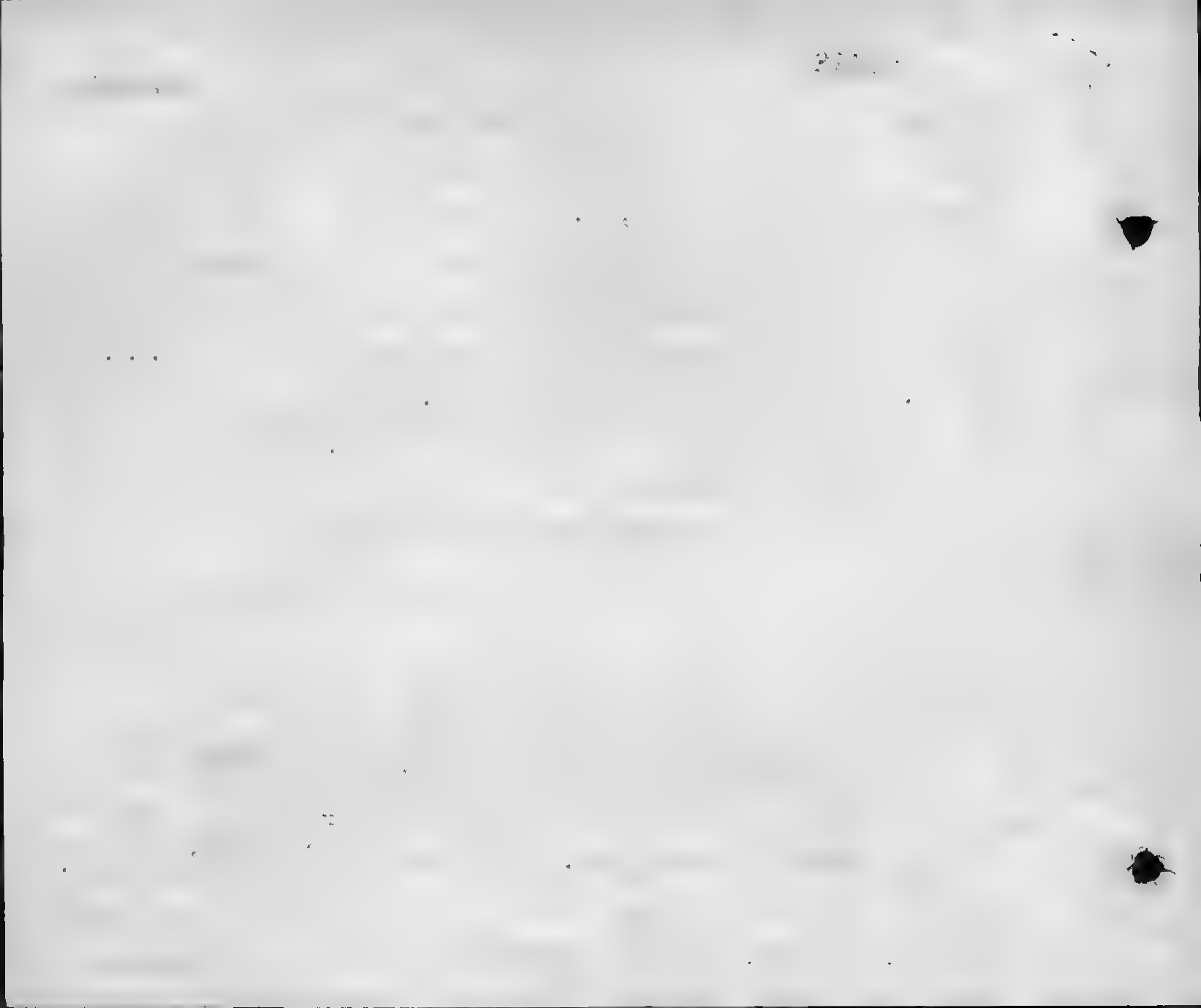
10348

CERTIFICATE OF DEATH

10343

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN town<br><b>18 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b> |   | 2. USUAL RESIDENCE (Where deceased lived, if institution, give institution address)<br>a. STATE<br><b>West Virginia</b><br>b. COUNTY<br><b>Gassaway</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Box 333</b><br>d. STREET ADDRESS<br><b>Box 333</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Burton Lee Cutlip</b>   |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>9</b> Year <b>19 61</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>March 28, 1892</b>                                      |
| 9. AGE (in years last birthday)<br><b>69 yrs.</b>  |   | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>18</b> Hours <b>15</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>George L. Cutlip</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Singleton</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>Unascertainable</b>   |  |
| 17. INFORMANT<br><b>The Medical Records</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypotension</b><br>465X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>Pulmonary embolus and myocardial infarction<br>DUE TO<br>24 hours<br>24 hours |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Multiple myeloma</b>   |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20. INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)<br><b>Unascertainable</b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (1) (this hospital) attended the deceased from <b>August 22, 19 61</b> to <b>September 9, 19 61</b> that (2) (we) last saw the deceased alive on <b>September 9, 19 61</b> , and that death occurred at <b>7:05 AM</b> from the causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Edward S. Henderson, M.D.</b>   |   | 22b. DATE SIGNED<br><b>9/9/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Edward S. Henderson, M.D.</b>   |   | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>9/11/61</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cutlip Burial Grounds</b>  | 23d. LOCATION (City, town or county) (State)<br><b>Gassaway, West Virginia</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br><b>SEP 14 61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>  |   | 25c. DATE<br><b>SEP 14 61</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| <b>10349</b><br>1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY (in days) <u>11 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium Hospital</u>   |  | <b>10344</b><br>2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>1205 Ruppert Rd.</u> |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Clay Vernon Davis</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>4. DATE OF DEATH<br>Last First Middle Day Month Year<br><u>Davis</u> <u>Sept</u> <u>5</u> <u>19</u> <u>61</u>  |  |
| 5. SEX <u>Male</u><br>6. COLOR OR RACE <u>White</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>9-27-87</u><br>9. AGE (in years last birthday) <u>73</u> yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Fiscal Officer</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Allen Davis</u><br>14. MOTHER'S M.A.DEN NAME <u>Allean Stone</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u><br>(If yes, give war or dates of service) <u>WWI Army 24-14-1982</u><br>16. SOCIAL SECURITY NO. <u>24-14-2982</u><br>17. INFORMANT <u>Mrs. Allean Wentzel</u> Address <u>Silver Spring, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pul. Embolism</u><br>DUE TO (b) <u>Broncho pneumonia bilat.</u><br>DUE TO (c) <u>Emphysema of chest</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>3 days</u><br><u>3 yrs.</u> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19____   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____  |  | 20f. (City or town) _____ (County) _____ (State) _____   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> to <u>9-5</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>9-5</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <u>Howard T. Morse</u> M.D.<br>22c. PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>   |  | 22b. DATE SIGNED _____<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS <u>7030 Carroll Avenue, Takoma Park</u>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>9/8/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>   |  | 23d. LOCATION (City, town or county) <u>Prince George's County Maryland</u> (State) _____  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Zisk</u> ADDRESS <u>34 Georgia Avenue</u><br><u>Patricia E. Proprey, Inc.</u> <u>Silver Spring, Maryland</u>   |  | 25a. RECD BY REGISTRAR <u>SEP 8 1961</u><br>25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>   |  |



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the general director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10350

Items 22 Film G-94 9/13/61 LWK

10345

|   |  |                                   |  |  |  |  |  |
|---|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  |                                   |  | 2. USUAL RESIDENCE (Where deceased lived, if non-tuition; residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>monty</u>                       |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>  |  |                                   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>   |  |  |  |
| c. LENGTH OF STAY IN 1b <u>Life</u>   |  |                                   |  | d. STREET ADDRESS <u>Emory Grove Rd</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |                                   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>James</u> Middle <u>Eduard</u> Last <u>Davis</u>  |  |                                   |  | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>2</u> Year <u>1961</u>  |  |  |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>col</u>       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Jan 17, 1896                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (State or foreign country) <u>md</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>                        |  |
| 13. FATHER'S NAME <u>Thomas Davis</u>   |  |                                   |  | 14. MOTHER'S MAIDEN NAME <u>Betty Watson</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                                   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>Betty Davis - Gaithersburg md</u><br>Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>20g. INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> |  |                                   |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. DATE SIGNED <u>9-2-61</u><br>EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> Address (Street, city, town, or county)   |  |                                   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF                 |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or country) (State)                   |  |
| <u>Burial</u>   |  | <u>9-8/61</u>                     |  | <u>Arlington National</u>  |  | <u>Arlington, Virginia</u>                                       |  |
| 23. FUNERAL DIRECTOR<br><u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>   |  |                                   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 8 '61</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kneale</u>            |  |

MEDICAL CERTIFICATION

22 - A  
y f 2





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

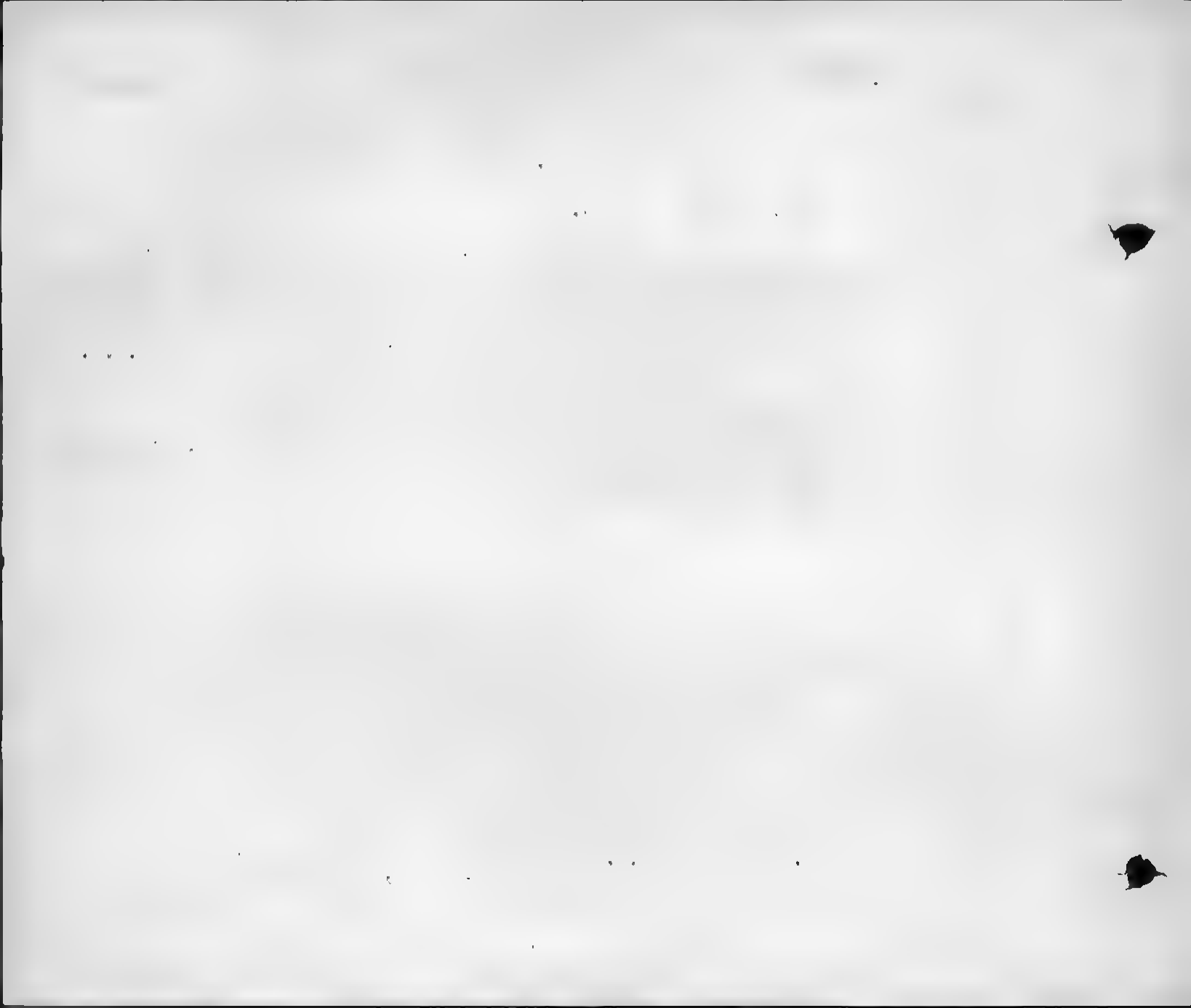
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10351

Reg. Dist. No. 10346

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Tazewell</b>        |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |  |  | c. LENGTH OF STAY in 1b<br><b>1 hour 10 Min.</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  |  |  | d. STREET ADDRESS<br><b>Route # 1</b>   |  |   |  |
|   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Patricia</b> Middle <b>Friel</b> Last <b>Davis</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>7</b> Year <b>1961</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>                 |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 8, 1959</b>  |  |
| 9. AGE (In years last birthday)<br><b>2</b> yrs   |  | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>7</b> |  | IF UNDER 24 HRS<br>Hours <b>10</b> Min <b>10</b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  |
| 13. FATHER'S NAME<br><b>Delmer Davis</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Show</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |  |  | 16. SOCIAL SECURITY NO<br><b>None</b>   |  | 17. INFORMANT<br><b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>   |  |  |  |   |  |   |  |
| DUE TO (b) <b>Heat exhaustion</b>   |  |  |  |   |  |   |  |
| DUE TO (c) <b>Cystic fibrosis</b>   |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                  |  |
|   |  |  |  | 20f. (City or town)   |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>September 7, 1961</b> , to <b>September 7, 1961</b> , that I last saw the deceased alive on <b>September 7, 1961</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above. |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>P. B. Schneider</i> M.D.   |  |  |  | ADDRESS (Street, city or town, state)<br><b>The Clinical Center</b>   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Peter B. Schneider, M.D.</b>  |  |  |  | DATE SIGNED<br><b>9/7/61</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>SHIP R.R.</b>   |  |  |  | 22b. DATE THEREOF<br><b>9-8-61</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY  |  |
|   |  |  |  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>RICHLANDS VA</b>                                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>W. W. Chambers</i>   |  |  |  | ADDRESS<br><b>1400 Chapin St N.W.</b>   |  | 24a. REG'D BY REGISTRAR<br><b>SEP 11 '61</b>  |  |
|   |  |  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><i>W. W. Chambers</i>   |  |



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

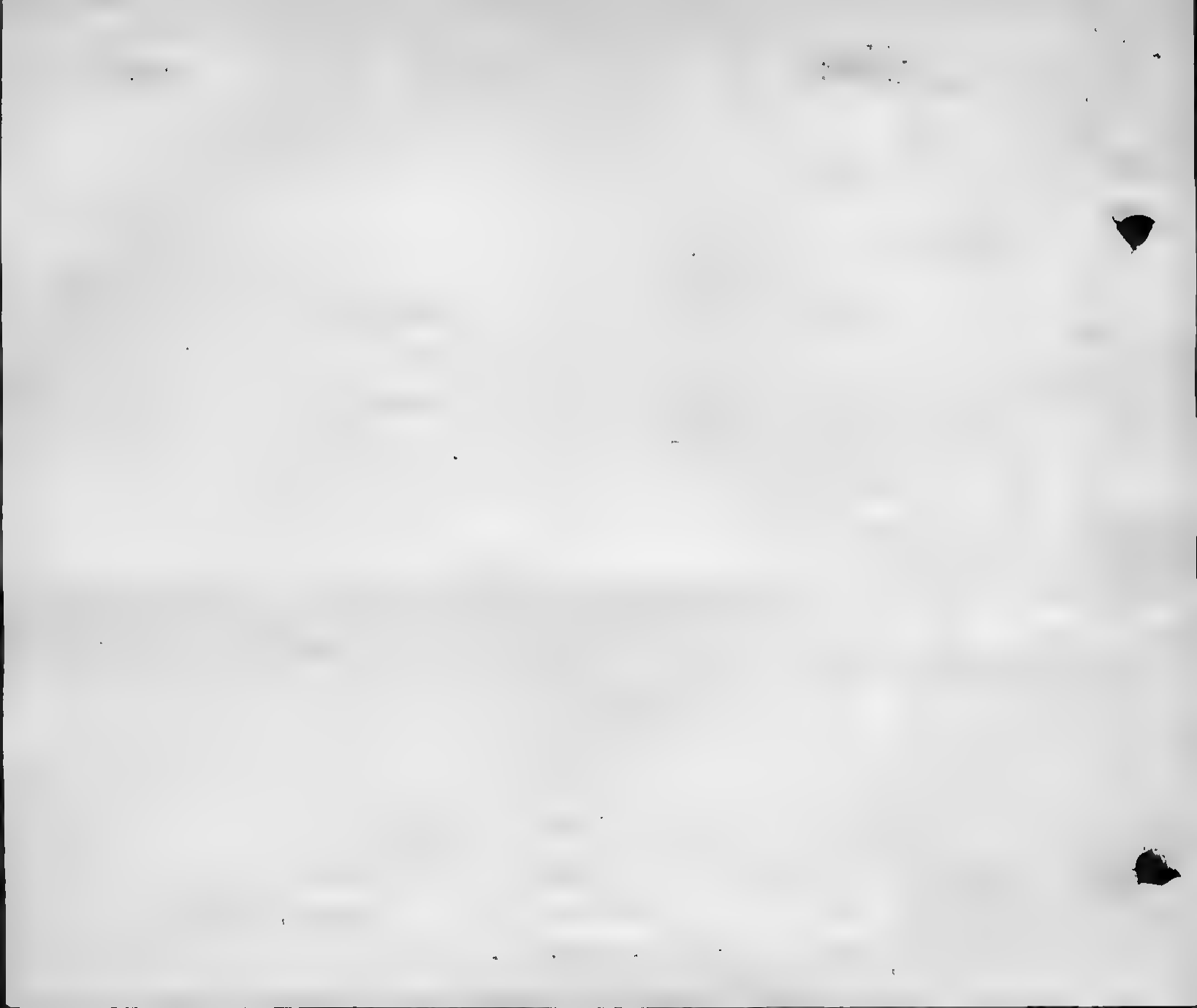
ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

23. FUNERAL DIRECTOR

Tyson Wheeler Funeral Home-1331 E. Montg. Ave.  
Rockville, Maryland

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |  |  |  |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 10352   |  | Montgomery  |  | MARYLAND   |  | 10347  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)   |  | Rockville   |  | c. LENGTH OF STAY IN 1b   |  | 11   |  | Rockville  |  | c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | 1300 Viers mill Rd.   |  | d. STREET ADDRESS   |  | 11300 Viers mill Rd.   |  | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | b. COUNTY   |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | Sybil   |  | 4. DATE OF DEATH  |  | Sept 28  |  | 1961   |  | c. DATE OF BIRTH  |  |
| 5. SEX  |  | Female  |  | 6. COLOR OR RACE  |  | White  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                       |  | housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)                              |  | Virginia   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME   |  | Floyd Atkins  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                        |  | 16. SOCIAL SECURITY NO.  |  | 298-24-0255  |  | 17. INFORMANT   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)   |  | Herniation of brain stem  |  | Charles E. Davis - Item # 2  |  | Interval between onset and death   |  | Found dead in bed.  |  |
| 9. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                 |  | 9. 1. 9.  |  | DUE TO (b)  |  | Intercerebral & pulmonary edema  |  | DUE TO (c)   |  | Aspiration of gastric contents  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) |  | 20c. TIME OF INJURY  |  | 20d. INJURY OCCURRED   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |  |
| 20c. TIME OF INJURY   |  | Month, Day, Year  |  | 20d. INJURY OCCURRED  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)  |  | (County) (State)  |  |
| 20c. TIME OF INJURY   |  | Hour a.m. p.m.  |  | 20d. INJURY OCCURRED  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)  |  | (County) (State)  |  |
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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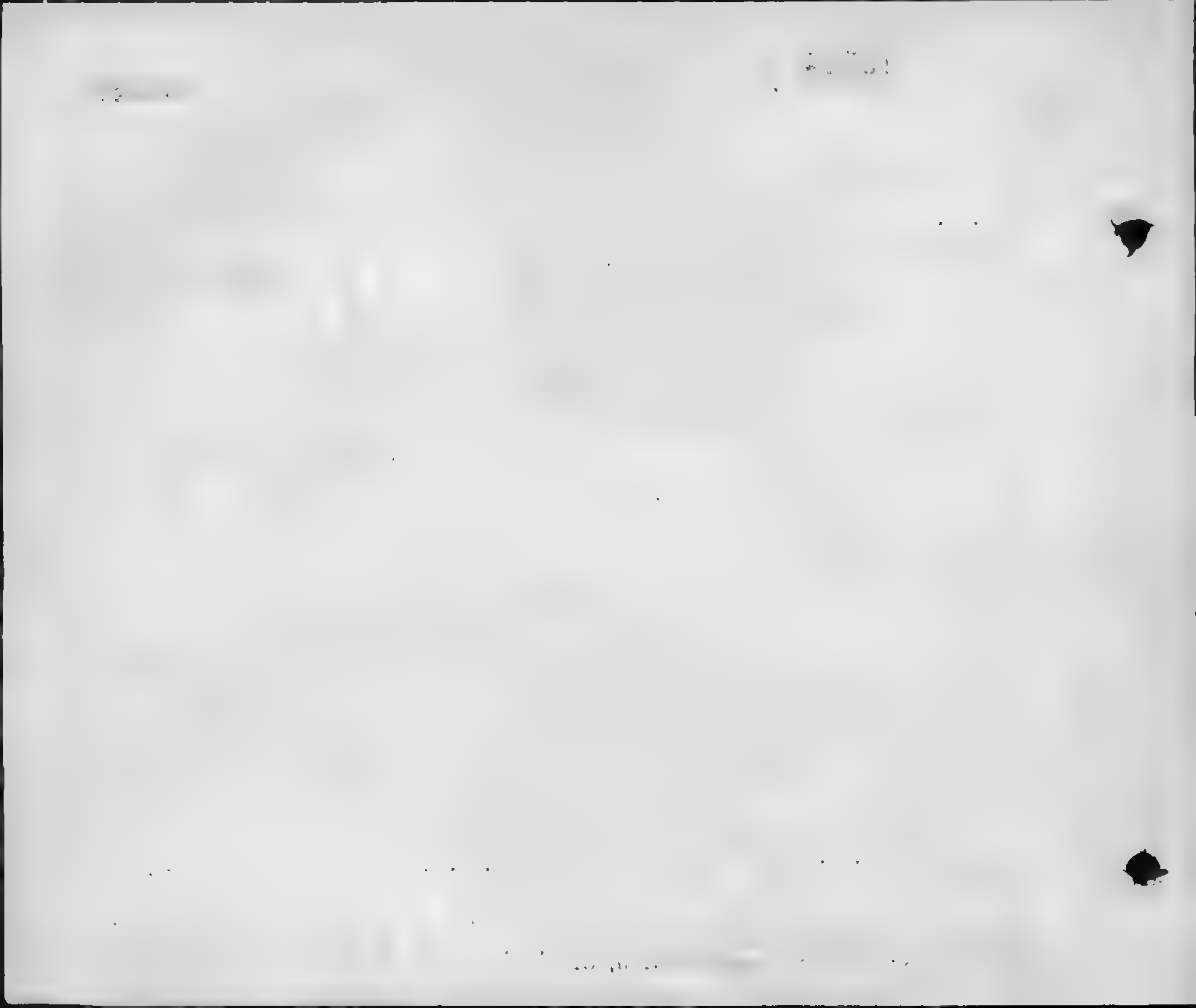
## CERTIFICATE OF DEATH

10349

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN IL <u>19 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, give name of institution)<br>a. STATE <u>Maryland</u> <b>b. COUNTY</b> <u>Frederick</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>d. STREET ADDRESS <u>11820 Old Drovers Way</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Marie Barbara Dieux</u>   |  | <b>4. DATE OF DEATH</b><br><u>September 24 1961</u>  |  | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-15-96</u>   |  |  |  |
| <b>9. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>France</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |  | <b>13. FATHER'S NAME</b> <u>Joseph Thirion</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>Mrs. Daniel R. Berg</u>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u><br>Hour a.m. <u>9:45</u> p.m.  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hospital, Bethesda, Md.</u>  |  |  |  |
| <b>20f. (City or town)</b> <u>Bethesda</u> <b>(County)</b> <u>Montgomery</u> <b>(State)</b> <u>Md.</u>   |  | <b>21. I certify that (X) (this hospital) attended the deceased from Sept. 5, 1961 to Sept. 24, 1961, that (X) (we) last saw the deceased alive on Sept. 24, 1961, and that death occurred at 9:45 AM, from the causes and on the date stated above.</b> |  |   |  |  |  |
| <b>22a. SIGNATURE</b> <u>W. F. Warrender</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <u>25 Sept 1961</u>  |  | <b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. F. WARRENDER, LT MC USN</u>  |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>28 Sept 1961</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>  |  | <b>23d. LOCATION (City, town or county)</b> <u>Arlington</u> <b>(State)</b> <u>Va.</u>  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis J. Collins</u> <b>ADDRESS</b> <u>3621 14th Street, N. W. Washington, D. C.</u>  |  | <b>25a. REC'D BY REGISTRAR</b> <u>SEP 27 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>C. J. ...</u>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10348

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|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>         |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>1 week</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carver Convalescent Home</u>   |  |   |  | d. STREET ADDRESS <u>8802-48th Ave</u> <u>1170-3</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Benjamin Miller Dobbin</u>  |  |   |  | 4. DATE OF DEATH <u>Sept 12 1961</u>   |  |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>               |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Dec 12 1880</u>                                    |  |
| 9. AGE (In years last birthday) <u>80</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.  |  | IF UNDER 24 HRS  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u>              |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>William John Dobbin</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Sarah Ann Stewart</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>511-36-5536</u>   |  | 17. INFORMANT <u>Paul Dobbin 8802-48th Ave. College Park, Md</u>       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u>  |  |   |  |  |  |  |  |
| Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u>   |  |   |  |  |  |  |  |
| (c) <u>"Years"</u>   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate with skeletal metastasis</u>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1960</u> to <u>12 Sept. 1961</u> , that (I) (we) last saw the deceased alive on <u>5 Sept 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above |  |   |  |  |  |  |  |
| 22a. SIGNATURE <u>J. Frederick Barr</u>  |  |   |  | 22b. DATE SIGNED <u>12 Sept '61</u>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>J. FREDERICK BARR MD</u>   |  |   |  | 22d. ADDRESS <u>4500 College Ave, College Park, Md.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>Sept. 16, 1961</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Richmond Cemetery</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Richmond, Kansas</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>SEP 14 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>                      |  |



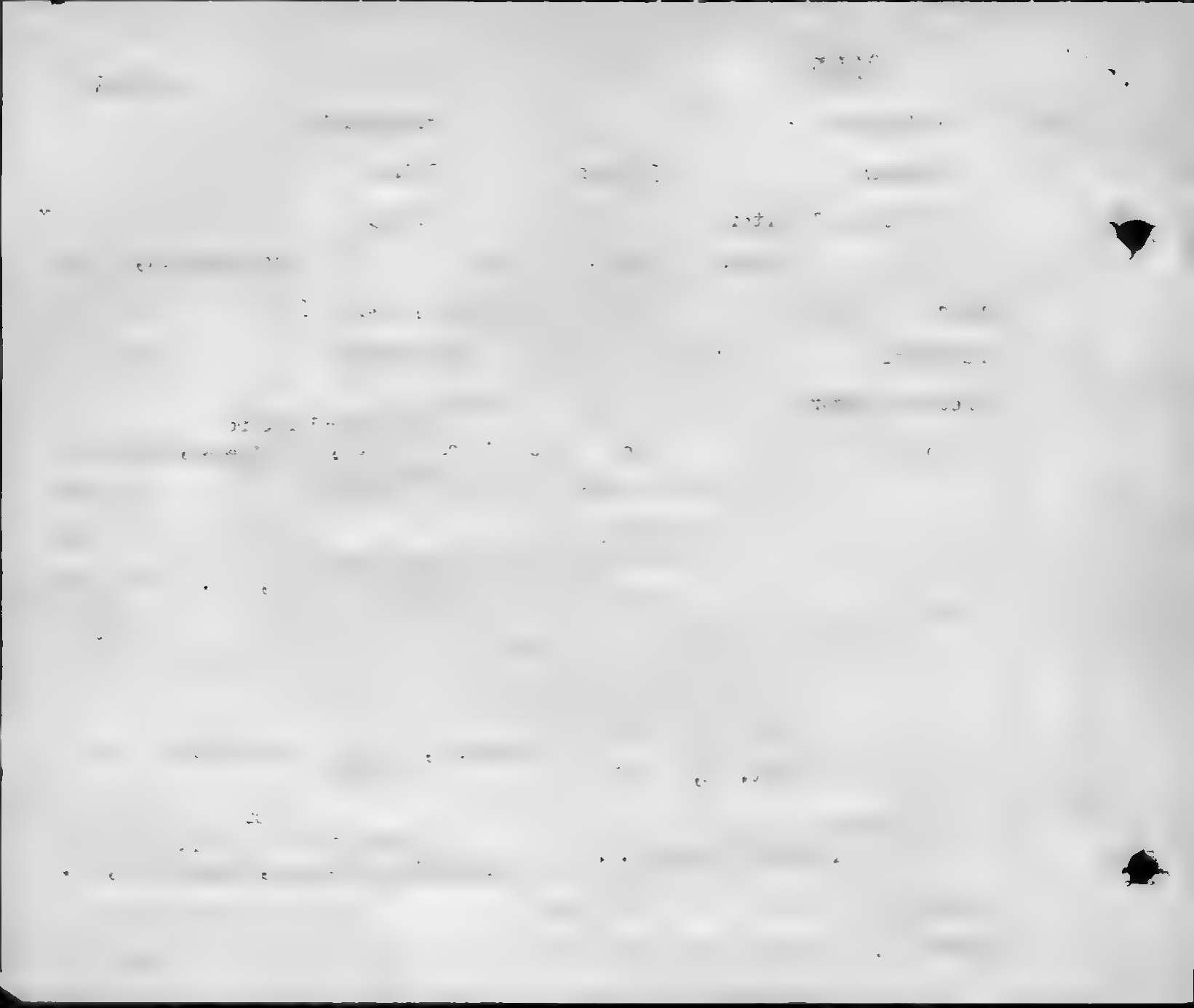


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |
|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |
| 10355   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if not in on Residence Certificate Mission)<br>a. STATE <b>Pennsylvania</b><br>b. COUNTY <b>Elgin</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 115</b><br>d. STREET ADDRESS <b>75X</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b <b>36 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>11</b> Year <b>19 61</b><br>5. SEX <b>Female</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>September 4, 1925</b><br>9. AGE In years <b>36</b> yrs. If UNDER 1 YEAR Months Days If UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembler</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>Private Industry</b><br>11. BIRTHPLACE County & State, or foreign country <b>Pennsylvania</b><br>12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 13. FATHER'S NAME <b>Theodore McCray</b><br>14. MOTHER'S MAIDEN NAME <b>Cleo McCray</b><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b><br>16. SOCIAL SECURITY NO. <b>None</b><br>17. INFORMANT <b>The Medical Record</b><br>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>(a) IMMEDIATE CAUSE <b>marked pulmonary congestion and edema</b><br>(b) <b>Panniculitis, severe</b><br>(c) <b>Myelogenous leukemia with involvement of liver spleen and &amp; kidneys, etc.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Septicemia</b><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. TIME OF INJURY<br>Hour a.m. <b>19</b><br>p.m.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br>20d. (City or town) (County) (State)   |  |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>August 6, 1961</b> to <b>September 11, 1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>Sept. 11, 1961</b> , and that death occurred at <b>10:30AM</b> from the causes and on the date stated above. |  | 22a. SIGNATURE <b>J. David Heywood</b> M.D.<br>22b. DATE SIGNED <b>9/11/61</b><br>22c. PHYSICIAN'S NAME (Type) <b>J. David Heywood, M.D.</b><br>22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b><br>23b. DATE THEREOF <b>9/12/61</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>Elgin Cemetery</b><br>23d. LOCATION (City, town or county) (State) <b>Cory Pennsylvania</b>   |  | 25a. REC'D BY REGISTRAR <b>SEP 14 '61</b><br>25b. REGISTRAR'S SIGNATURE <b>Clifford L. Kraus</b>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

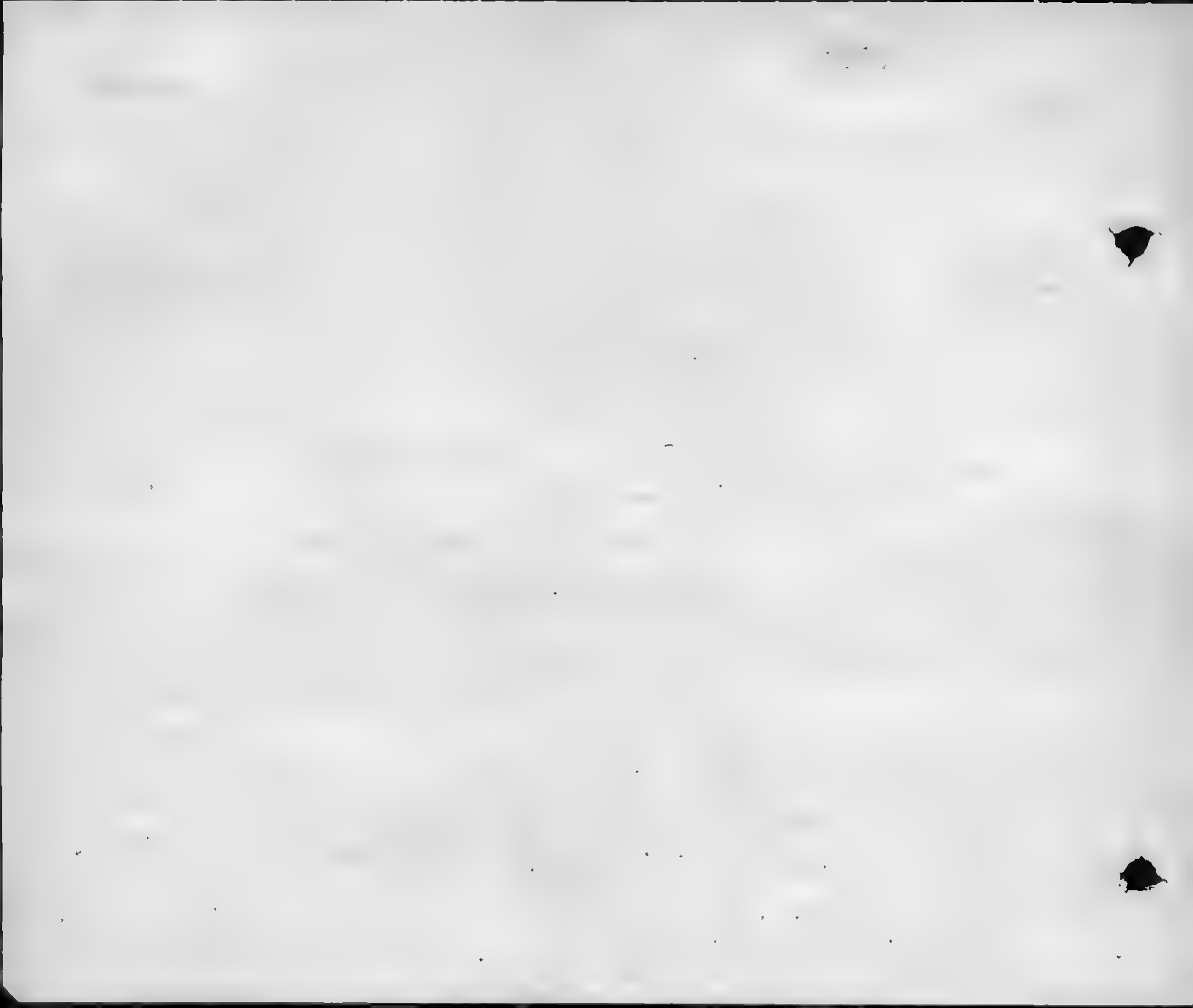
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|---|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>6 weeks</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hospital</u>    |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institutions, residence, or hospital admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>8408 Ramsey Ave 1</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Esther May Eaton</u>   |   | <b>4. DATE OF DEATH</b><br>Month <u>Sept.</u> Day <u>3</u> Year <u>1961</u>  |   |
| <b>5. SEX</b><br><u>Female</u>  | <b>6. COLOR OR RACE</b><br><u>White</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><u>3-13-22</u> |
| <b>9. AGE</b> (In years, last birthday) <u>39</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>  |   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife-Secretary-Eaton Refrigeration Company</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |   |
| <b>13. FATHER'S NAME</b><br><u>John Stewart</u>   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Clara Stokes</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>   |   | <b>16. SOCIAL SECURITY NO.</b> <u>577-26-1725</u><br><b>17. INFORMANT</b> <u>Hospital Records</u> Address <u>  </u>  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A. Fibrillation</u><br>DUE TO (b) <u>Rheumatic Heart Disease</u><br>DUE TO (c) <u>Pleural Effusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |   |  |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |   | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |   | <b>20f. (City or town)</b> (County) (State) <u>  </u>  |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/23/61</u> , to <u>9/3/61</u> , that (I) (we) last saw the deceased alive on <u>9/3/61</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.   |   |  |   |
| <b>22a. SIGNATURE</b><br><u>Robert A. Hare</u>  |   | <b>22b. DATE SIGNED</b><br><u>9/3/61</u>   |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Robert A. Hare MD</u>   |   | <b>22d. ADDRESS</b><br><u>7600 Carroll Ave., T. TX, Md.</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>BURIAL</u>   |   | <b>23b. DATE THEREOF</b><br><u>SEPT. 6, 1961</u>   |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>FORT LINCOLN CEMETERY</u>   |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>PRINCE GEORGE'S COUNTY, MD.</u>  |   |
| <b>24. PREPARED BY</b><br><u>Raymond A. Ziska</u>   |   | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 6 '61</u>   |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Hume</u>  |   | <b>25c. ADDRESS</b><br><u>SILVER SPRING, MD.</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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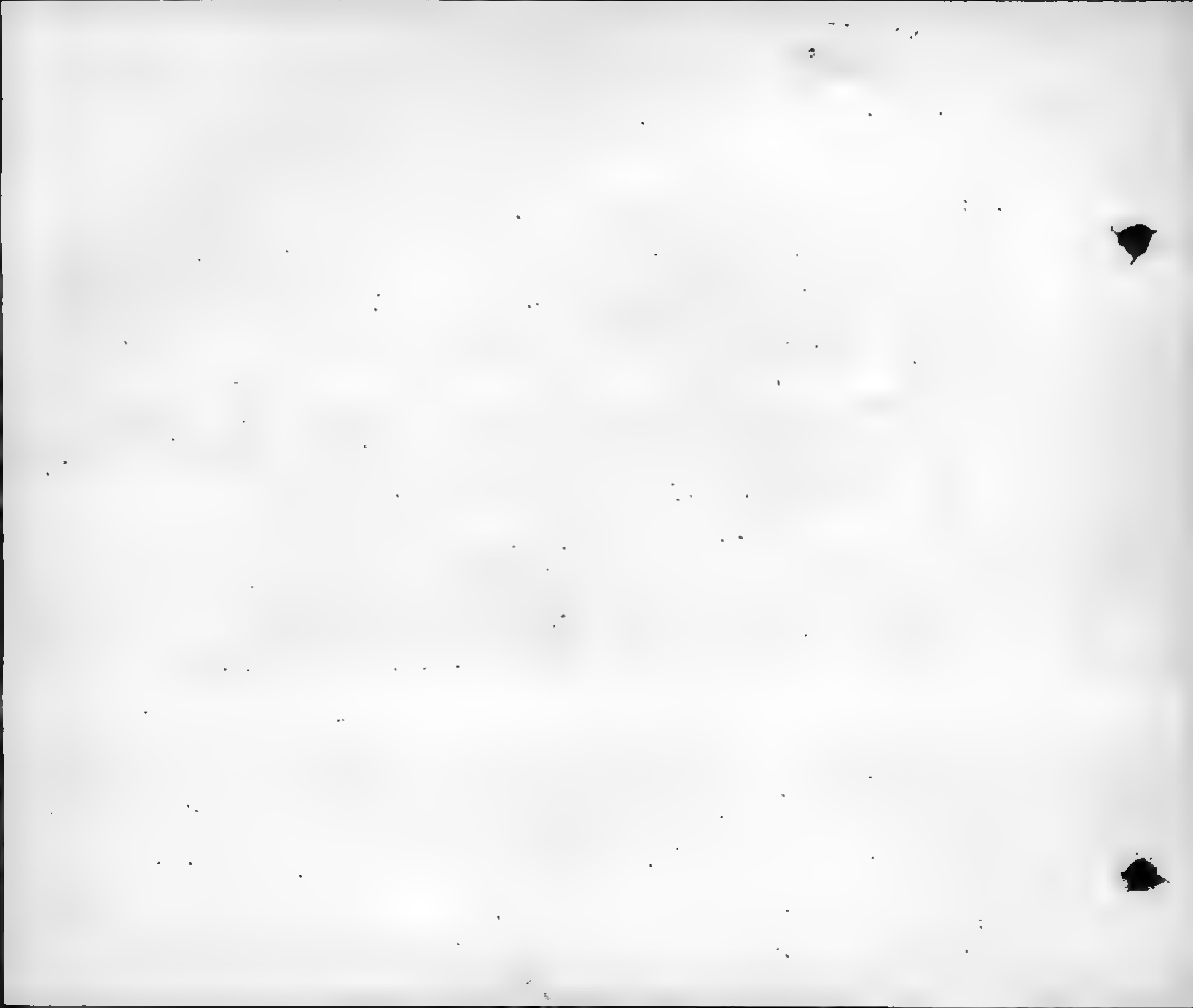
## CERTIFICATE OF DEATH

Reg. Dist. No. 10352

|  |                                  |  |   |   |  |   |  |
|--|----------------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>   |                                  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg MD</u>                            |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>MARILEA NURSING HOME</u>  |                                  |  |   | d. STREET ADDRESS<br><u>10371 Frederick ave</u>   |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>ALICE MAY ENGLE</u>  |                                  |  |   | 4. DATE OF DEATH Month Day Year<br><u>September 1, 1961</u>   |  |   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 25, 1896</u> | 9. AGE (In years last birthday)<br><u>65</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min | IF UNDER 24 HRS<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during major working life)<br><u>Housewife</u>   |                                  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Robertson Ind.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>USA</u>                               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                  |  |   |   |  |   |  |
| 13. FATHER'S NAME<br><u>John Engle</u>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Sophia Lutz</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                                  |  |   | 16. SOCIAL SECURITY NO<br><u>1637</u>   |  |   |  |
| 17. INFORMANT<br><u>Mrs Emma Ellis, Gaithersburg</u>   |                                  |  |   | Address<br><u>603 North Frederick</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNGS</u><br><u>1637</u> DUE TO<br>Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO<br>(c) <u>Generalized Arteriosclerosis</u><br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Generalized, moderate, osteoarthritis</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> |                                  |  |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour <u>1</u> p. m. 19  |                                  |  |   | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> No while at work <input type="checkbox"/>                   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u> |  |
| 20f. (City or town)<br><u>Silver Spring</u>  |                                  |  |   | (County)<br><u>Montgomery</u>   |  | (State)<br><u>Md</u>  |  |
| 21. I certify that I attended the deceased from <u>Sept. 1, 1961</u> , to <u>Sept. 1, 1961</u> , that I last saw the deceased alive on <u>Sept. 1, 1961</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.   |                                  |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><u>Belden R. Reap</u> M.D.   |                                  |  |   | ADDRESS (Street, city or town, state)<br><u>11502 GRANDVIEW AVE, Sept. 1, 1961</u>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>BELDEN R. REAP M.D.</u>  |                                  |  |   | DATE SIGNED<br><u>1961</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Buried</u>   |                                  |  |   | 22b. DATE THEREOF<br><u>9-3-61</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Forest Oak</u>                               |  |
| 22d. LOCATION (City, town or county)<br><u>Gaithersburg</u>  |                                  |  |   | (State)<br><u>Md</u>  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Frederick B. Garbur</u>   |                                  |  |   | ADDRESS<br><u>Gaithersburg</u>  |  | 24a. REC'D BY REGISTRAR<br><u>SEP 5 '61</u>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Carlton S. Haines</u>   |                                  |  |   |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

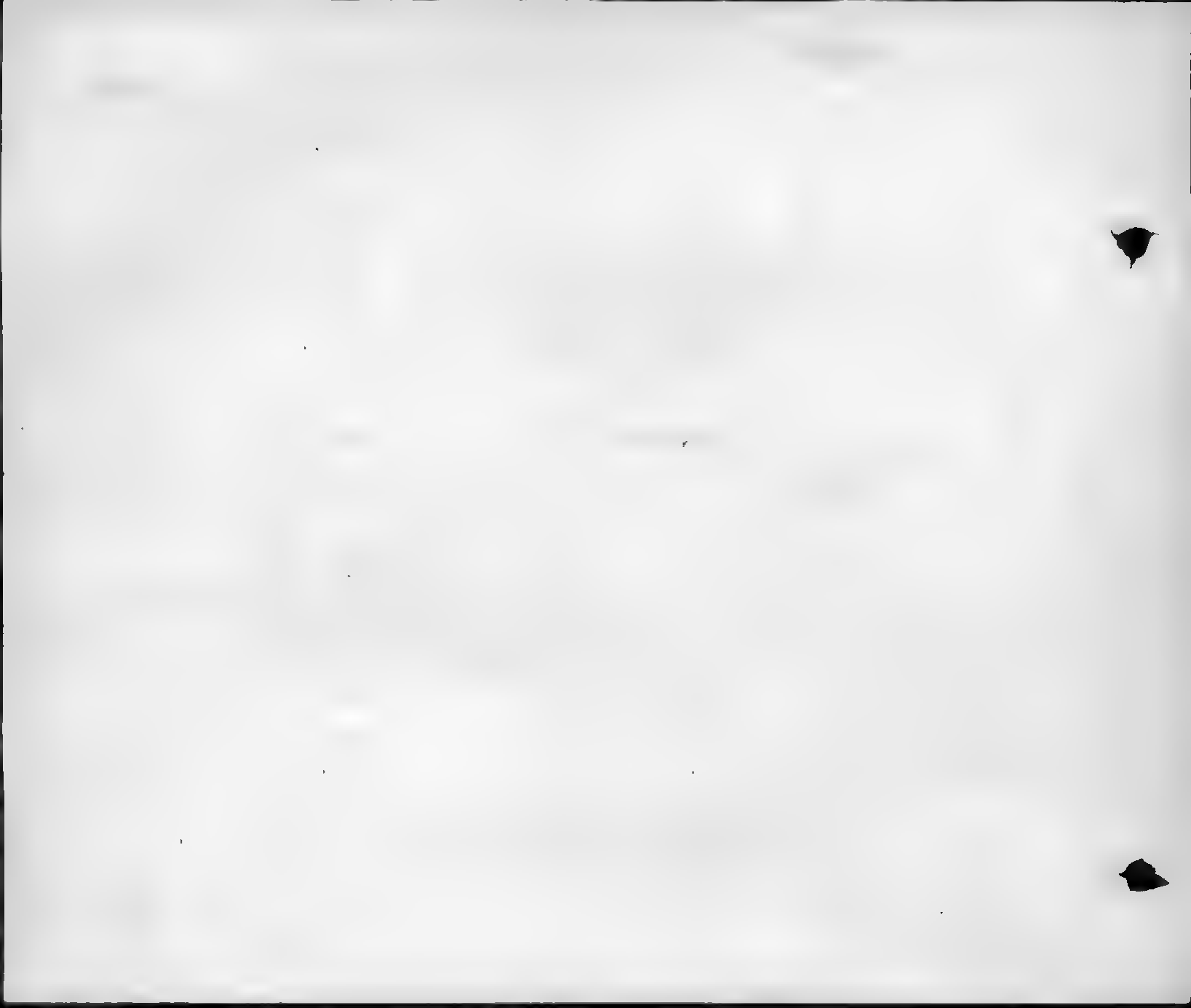
10358  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

|   |                              |   |  |
|---|------------------------------|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                              | 2 USUAL RESIDENCE (Where deceased lived) If institution, residence as per admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1740 WISCONSIN AVENUE</u>   |                              | d. STREET ADDRESS <u>4890-BATTERY LANE</u>  |  |
| 3 NAME OF DECEASED (Type or print) <u>MORTON</u> First Middle Last  |                              | 4. DATE OF DEATH <u>9</u> Month <u>26</u> Day <u>1961</u> Year  |  |
| 5 SEX <u>male</u>   | 6 COLOR OR RACE <u>white</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>May 8, 1908</u>             |
| 9 AGE (In years last birthday) <u>53</u> yrs  |                              | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>   | IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER-</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY <u>CARPET STORE</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>  |                              | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>ISAAC FELKER</u>   |                              | 14. MOTHER'S MAIDEN NAME <u>CELIA TABOR</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                              | 16 SOCIAL SECURITY NO <u>578-12-5635</u>  |  |
| 17 INFORMANT <u>MILDRED FELKER</u> Address <u>4890-BATTERY LANE</u>   |                              |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary occlusion</u><br>DUE TO (c) <u>Arteriosclerotic heart disease</u> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 minutes</u><br><u>10 minutes</u><br><u>5 years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis, emphysema; bronchial asthma</u>  |                              |   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>  |                              | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f (City or town) (County) (State)   |  |
| 21 I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12-28</u> <u>1957</u> to <u>9-26</u> <u>1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>9-19</u> <u>1961</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above  |                              |   |  |
| 22a SIGNATURE <u>Jason Geiger</u>   |                              | 22b DATE SIGNED <u>9-26-61</u>  |  |
| 22c PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>   |                              | 22d ADDRESS <u>1110 SPRING STREET SILVER SPRING, MD.</u>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                              | 23b DATE THEREOF <u>9-28-61</u>   |  |
| 23c NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN.</u>  |                              | 23d LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>   |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY + SONS</u>  |                              | 25a REC'D BY REGISTRAR <u>SEP 29 '61</u>  |  |
| ADDRESS <u>3501-14th St. N.W.</u>   |                              | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>  |  |

X

1



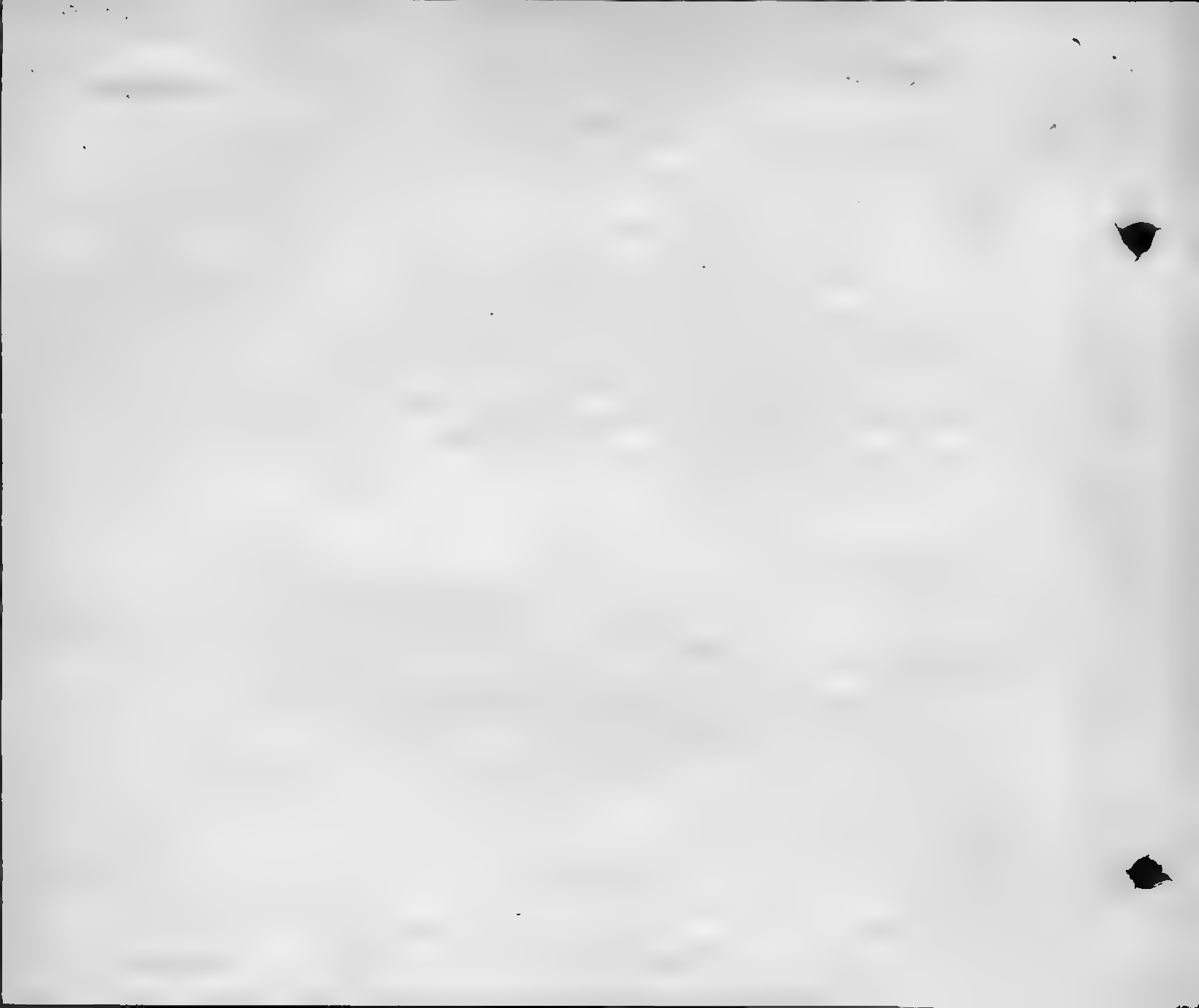


1.  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |  |  |                                      |  |   |  |   |  |
|--|--|-------------------------------|--|--|--|--------------------------------------|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |  |  |                                      |  |   |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                               |  |  |  |                                      |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |  |                               |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westmoreland Hills</u>   |  |                                      |  | c. LENGTH OF STAY IN 1b   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5301 Boxwood Ct</u>  |  |                               |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                      |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Mary E. Ferguson</u>  |  |                               |  | 4. DATE OF DEATH <u>Sept 16 1961</u>   |  |                                      |  | 5. STREET ADDRESS <u>5301 Boxwood Ct</u>  |  |   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>white</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Dec. 3, 1916</u> |  | 9. AGE (In years last birthday) <u>44</u> yrs.  |  | 10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>13</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>   |  |                                      |  | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>             |  |
| 13. FATHER'S NAME <u>Ivor Johns</u>  |  |                               |  | 14. MOTHER'S MAIDEN NAME <u>Jessie Fray</u>  |  |                                      |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |   |  |
| 16. SOCIAL SECURITY NO. <u>None</u>  |  |                               |  | 17. INFORMANT (H) Edward Ferguson-same 2d  |  |                                      |  | Address   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                               |  |  |  |                                      |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fatty liver</u>   |  |                               |  |  |  |                                      |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (b) <u>Acute &amp; chronic alcoholism</u>   |  |                               |  |  |  |                                      |  |   |  |   |  |
| (c) <u>-----</u>   |  |                               |  |  |  |                                      |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                               |  |  |  |                                      |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                               |  |  |  |                                      |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                               |  |  |  |                                      |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |                               |  |  |  |                                      |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |                                      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  |
| 20f. (City or town)  |  |                               |  | 20g. (County)  |  |                                      |  | 20h. (State)  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |  |                               |  |  |  |                                      |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>   |  |                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |                                      |  | DATE SIGNED <u>9-16-61</u>  |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>   |  |                               |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |                                      |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                               |  | 22b. DATE THEREOF <u>9/19/61</u>   |  |                                      |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>   |  |   |  |
| 22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u>  |  |                               |  | 22e. (State) <u>-----</u>  |  |                                      |  | 22f. (Country) <u>-----</u>   |  |   |  |
| 23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>   |  |                               |  | ADDRESS <u>Bethesda, Maryland</u>  |  |                                      |  | 24a. REC'D BY REGISTRAR <u>SEP 20 '61</u>   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>  |  |                               |  | 24c. (City, town, or country) <u>-----</u>   |  |                                      |  | 24d. (State) <u>-----</u>   |  |   |  |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10360

10355

|   |                               |  |                                       |   |  |  |  |
|---|-------------------------------|--|---------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>  |                               |  |                                       | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>   |                               |  |                                       | c. LENGTH OF STAY IN lb. <u>X</u> <u>Rockville</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>908 Viers Mill Rd</u>   |                               |  |                                       | d. STREET ADDRESS <u>15707 Coral Sea Ave</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>S.</u> Last <u>Flynn</u>  |                               |  |                                       | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>11</u> Year <u>1961</u>  |  |  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 17, 1884</u> | 9. AGE (In years last birthday) <u>77</u> yrs.  | 10. UNDER 1 YEAR Months <u></u> Days <u></u> | 11. UNDER 24 HRS. Hours <u></u> Min <u></u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u></u>  |                                       | 11. BIRTHPLACE (State or foreign country) <u>Germany</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Joseph Schoenberger</u>  |                               |  |                                       | 14. MOTHER'S MAIDEN NAME <u>Anna Wierkert</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   |                                       | 17. INFORMANT <u>George J. Flynn, Jr.</u>   |  | Address <u>Same as #2</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                               |  |                                       |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral infection</u><br>DUE TO <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>central thrombosis</u><br>DUE TO <u></u><br>(c) <u>central arteriosclerosis</u> |                               |  |                                       |   |  | <u>24 hrs</u><br><u>2 wks</u><br><u>Indefinite</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Failure</u>   |                               |  |                                       |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |                                       |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/2/1961</u> to <u>9/11/1961</u> , that (I) (we) last saw the deceased alive on <u>9/10/1961</u> , and that death occurred <u>2:30 PM</u> from the causes and on the date stated above                             |                               |  |                                       |   |  |  |  |
| 22a. SIGNATURE <u>Stephen N. Jones</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                               |  |                                       | 22b. DATE SIGNED <u>9/11/61</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES, M.D.</u>  |                               |  |                                       | 22d. ADDRESS <u>809 Viers Mill Rd, Rockville, Md.</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Spec. fy) <u>BURIAL</u>  |                               | 23b. DATE THEREOF <u>9/13/61</u>   |                                       | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Augustine</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Millvale, Allegheny Co., Pa.</u>              |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>1400 Chapin St, Wash, D.C.</u>   |                               |  |                                       | 25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Huns</u>  |  |

MEDICAL CERTIFICATION



**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

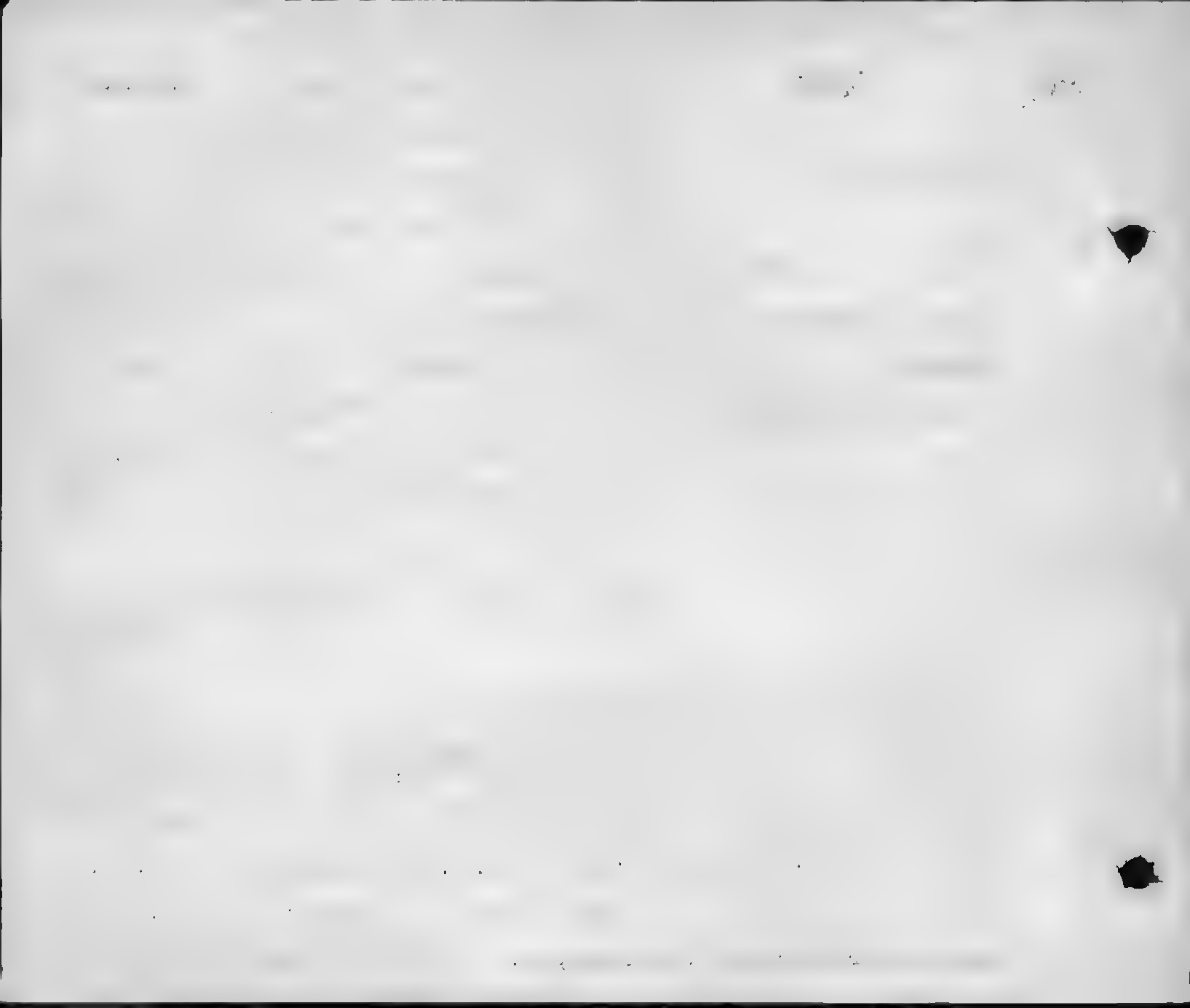
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
15M 9/60

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b> <span style="float: right; font-size: 1.5em;">10361</span><br><b>a. COUNTY</b><br><u>Montgomery</u><br><b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (Rural)</u><br><b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address)<br><u>U.S. Naval Hospital</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions, last prior to admission)<br><b>a. STATE</b><br><u>Maryland</u><br><b>b. COUNTY</b><br><u>Montgomery</u><br><b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u><br><b>d. STREET ADDRESS</b><br><u>711 Monroe Ave. Apt 102</u><br><b>e. IS RESIDENCE ON A FARM?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Belinda</u> <u>Carroll</u> <u>Fraleigh</u><br><b>5. SEX</b><br><u>Female</u><br><b>6. COLOR OR RACE</b><br><u>Caucasian</u><br><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Infant</u><br><b>13. FATHER'S NAME</b><br><u>Charles Malcolm Fraleigh</u>  |  | <b>4. DATE OF DEATH</b><br><u>September 25</u> <u>1961</u><br><b>19. AGE (in years last birthday)</b><br><u>5</u> <u>8</u> <u>1</u><br><b>IF UNDER 1 YEAR</b><br>Months <u>5</u> Days <u>8</u> Hours <u>1</u> Min.<br><b>8. DATE OF BIRTH</b><br><u>4-17-61</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Infant</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Virginia</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u><br><b>14. MOTHER'S MAIDEN NAME</b><br><u>Irleda Jean Franklin</u> |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u><br><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br><b>PART I. DEATH WAS CAUSED BY.</b><br><b>IMMEDIATE CAUSE (a)</b><br><u>Congenital Heart Disease (Ventricular Septal Defect)</u><br><b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>5 Mo.</u><br><b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), stating the underlying cause last.</b><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)</b> |  | <b>16. SOCIAL SECURITY NO.</b><br><u>(F) Charles M. Fraleigh Same as #2 above</u><br><b>17. INFORMANT</b><br><u>Irleda Jean Franklin</u><br><b>Address</b><br><u>711 Monroe Ave. Apt 102 Rockville, Md.</u><br><b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b><br>(If either, notify medical examiner)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>9</u> a.m. <u>19</u> p.m.<br><b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)<br><u>Rockville</u> <u>Montgomery</u> <u>Md.</u>  |  |
| <b>21. I certify that (X) (this hospital) attended the deceased from August 10, 1961 to Sept. 25, 1961 that (we) last saw the deceased alive on Sept. 25, 1961, and that death occurred at 9:00 PM from the causes and on the date stated above.</b><br><b>22a. SIGNATURE</b><br><u>James L. Beeby</u> <b>M.D.</b><br><b>22c. PHYSICIAN'S NAME (Type)</b><br><u>JAMES L. BEEBY, LT MC USN</u><br><b>22b. DATE SIGNED</b><br><u>September 26, 1961</u><br><b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b><br><u>SEP 28 '61</u> <u>Arthur S. Hines</u>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial - Shipment</u><br><b>23b. DATE THEREOF</b><br><u>9-26-61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Saunders Cemetery</u><br><b>23d. LOCATION</b> (City, town or county) (State)<br><u>Ranger</u> <u>West Virginia</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Tyson Wheeler</u><br><b>ADDRESS</b><br><u>Tyson Wheeler Funeral Home, Rockville, Md.</u>  |  |  |  |



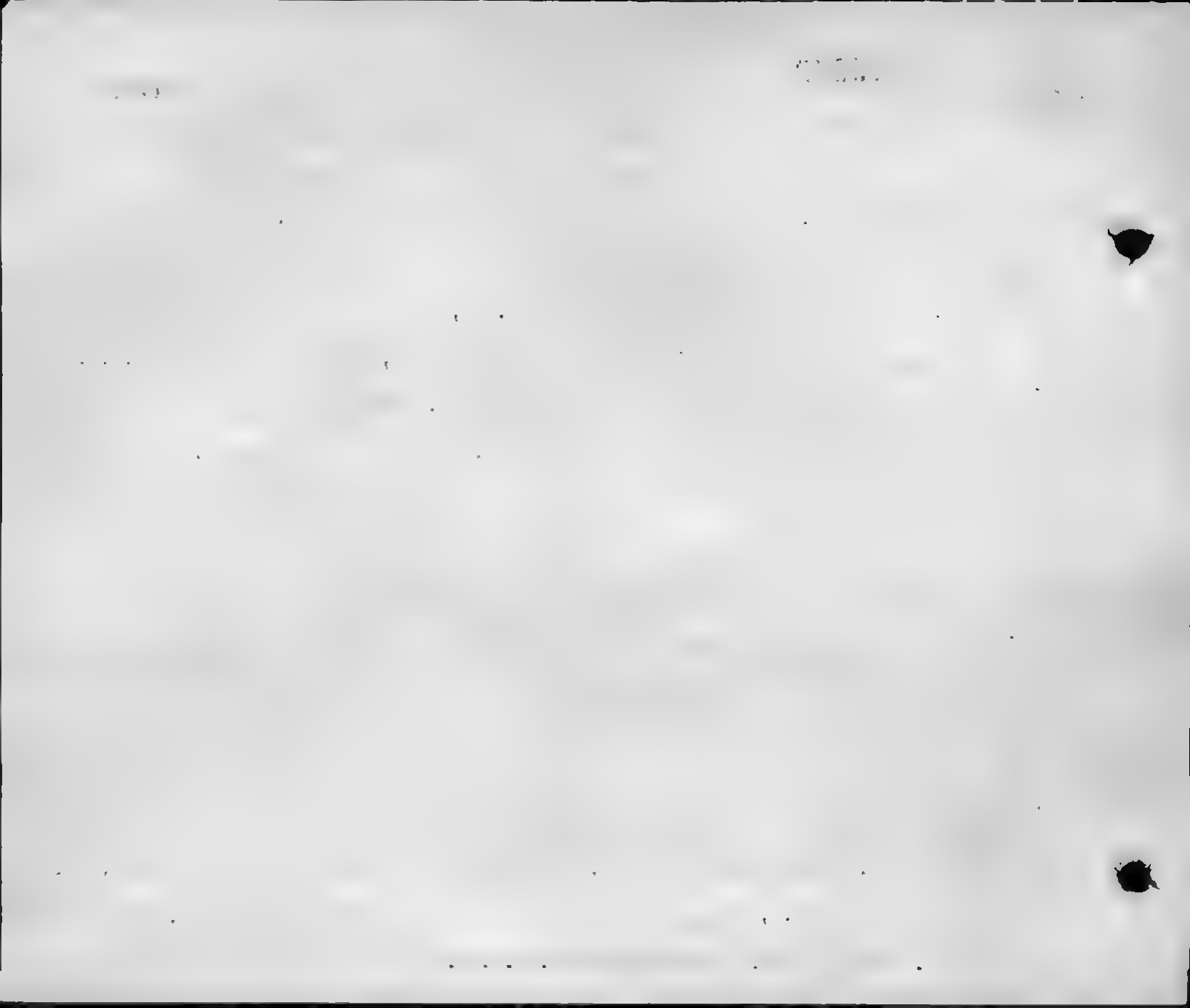
10362

10357

**MEDICAL CERTIFICATION**

VR A15 (4)  
15M 9/60

Coroner Notified and approved. 11



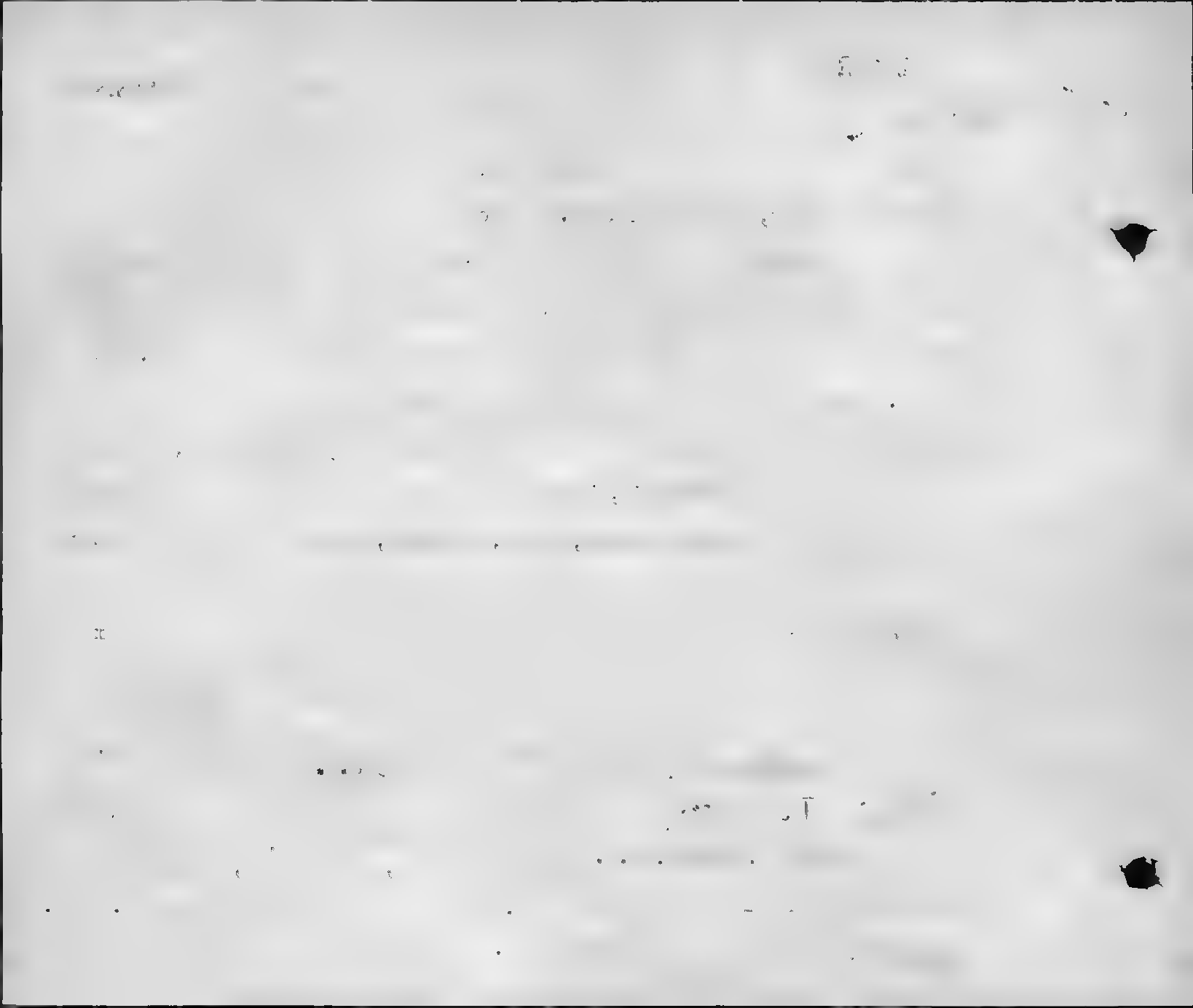


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10363  
CERTIFICATE OF DEATH

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN b<br><b>16 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution, give name of institution)<br>a. STATE<br><b>South Carolina</b><br>b. COUNTY<br><b>Greenville</b><br>c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town)<br><b>Box 3</b><br>d. STREET ADDRESS<br><b>Box 3</b> |  | 10358<br>a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Idalene Josie Gibson</b>  |  | 4. DATE OF DEATH<br><b>September 29, 1961</b>   |  | 7) X  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>July 25, 1902</b>   |  | 9. AGE (In years last birthday)<br><b>59 yrs</b>  |  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (County & State or foreign country)<br><b>South Carolina</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Thomas J. Hendricks</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Wood</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year of discharge)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO<br><b>None</b>   |  | 17. INFORMATION<br><b>The Medical Record</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>1-4-1</b><br>DUE TO<br><b>Atelectasis, lungs</b><br>Conditions, if any, which gave rise to immediate cause (b)<br><b>Cryptococcosis, brain, meninges, lungs</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>6 months</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)   |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>September 13, 1961</b>  |  |
| 20g. (County)  |  | 20h. (State)  |  | 20i. (City or town)<br><b>September 29, 1961</b>  |  |
| 20j. (State)   |  | 20k. (City or town)<br><b>4:55 a.m.</b>   |  | 20l. (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 29, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 29, 1961</b> , and that death occurred at <b>4:55 a.m.</b> from the causes and on the date stated above.   |  | 22a. SIGNATURE<br><b>William T. Butler</b>  |  | 22b. DATE<br><b>9/29/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>WILLIAM T. BUTLER, M.D.</b>   |  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>  |  | 22e. (City or town)   |  |
| 22f. (State)   |  | 22g. (City or town)   |  | 22h. (State)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Transit 9-30-61</b>  |  | 23b. DATE THEREOF<br><b>9-30-61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Granview Mem. Gardens</b>  |  |
| 23d. LOCATION (City, town or county)<br><b>Travelers Rest, So. Car.</b>  |  | 23e. (State)  |  | 23f. (City or town)   |  |
| 23g. (State)   |  | 23h. (City or town)   |  | 23i. (State)  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. TUMPHY</b>  |  | ADDRESS<br><b>Bethesda, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE OCT 4 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Tumphy</b>  |  | 25c. (City or town)   |  | 25d. (State)  |  |



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# MARYLAND STATE DEPARTMENT OF HEALTH

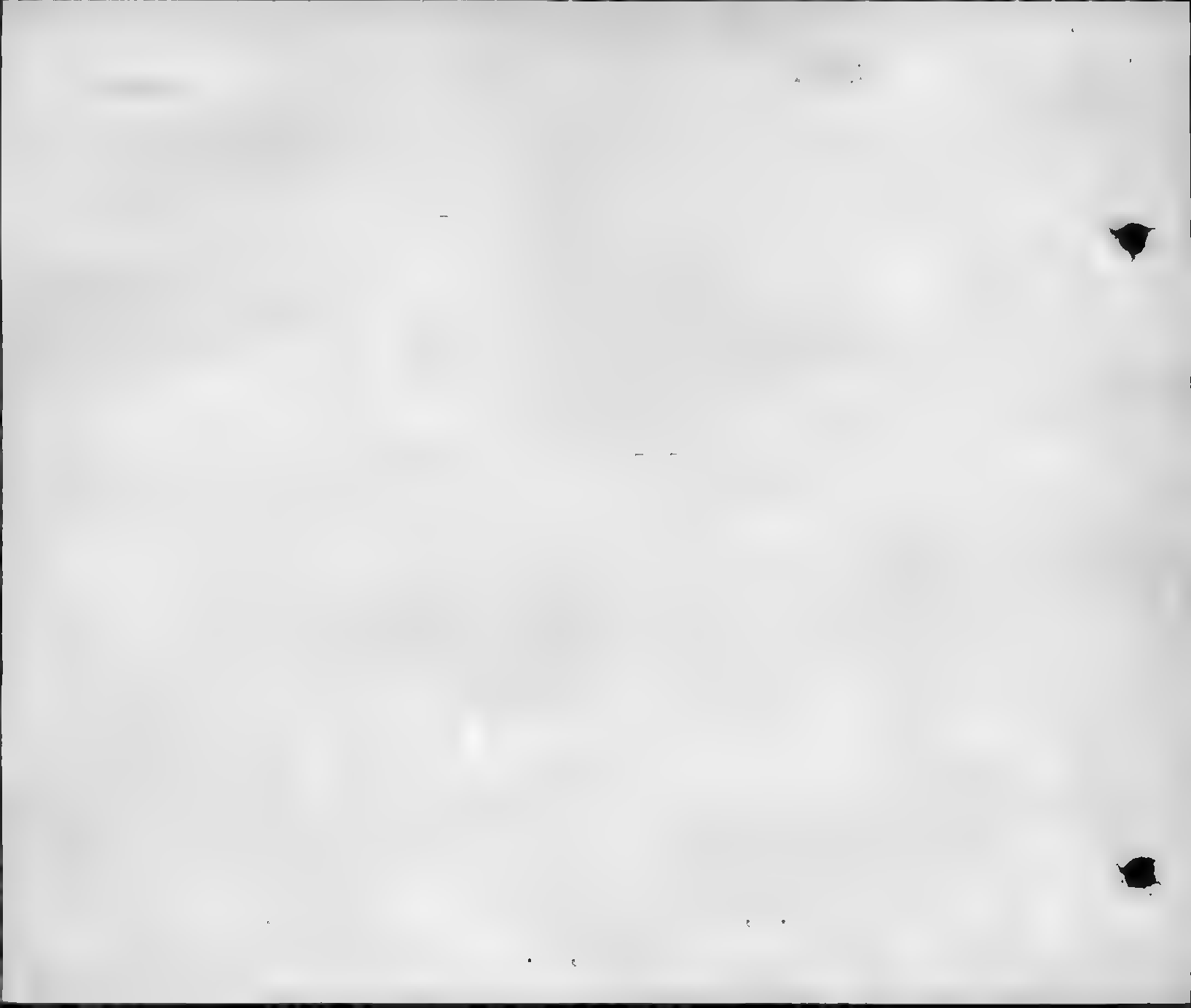
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10364

10359

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u><br>c. LENGTH OF STAY N 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MONTGOMERY GENERAL</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Reside in the same address)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BROOKVILLE</u><br>d. STREET ADDRESS <u>1</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>JAMES</u> Middle <u>FRANKLIN</u> Last <u>GIVENS</u>  |  | 4. DATE OF DEATH<br>Month <u>SEPTEMBER</u> Day <u>16</u> Year <u>1961</u>   |  |
| 5. SEX <u>MALE</u><br>6. COLOR OR RACE <u>WHITE</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>8. DATE OF BIRTH <u>DECEMBER 27, 1906</u><br>9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>TENNESSEE</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>GEORGE GIVENS</u><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u><br>16. SOCIAL SECURITY NO. <u>218-14-5701</u><br>17. INFORMANT <u>HOSPITAL RECORDS</u><br>Address <u>10-101 BURGHEIT</u>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>-</u><br>(c), stating the underlying cause last. DUE TO (c) <u>-</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>-</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>-</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u><br>20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u> |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-15</u> , 19 <u>61</u> , to <u>9-16</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>61</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE <u>Charles S. Whitaker, M.D.</u><br>22c. PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D.</u>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS <u>CLARKSVILLE, MARYLAND</u>  |  |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u><br>23b. DATE THEREOF <u>Sept. 19, 1961</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>Seal's Farm Cemetery</u><br>23d. LOCATION (City, town or county) <u>Etchison, Maryland</u> (State) <u>-</u>  |  | 25a. REC'D BY REGISTRAR <u>SEP 19 '61</u><br>25b. REGISTRAR'S SIGNATURE <u>Charles S. Whitaker</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u><br>ADDRESS <u>Laytonville, Md.</u>  |  |   |  |



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# MARYLAND STATE DEPARTMENT OF HEALTH

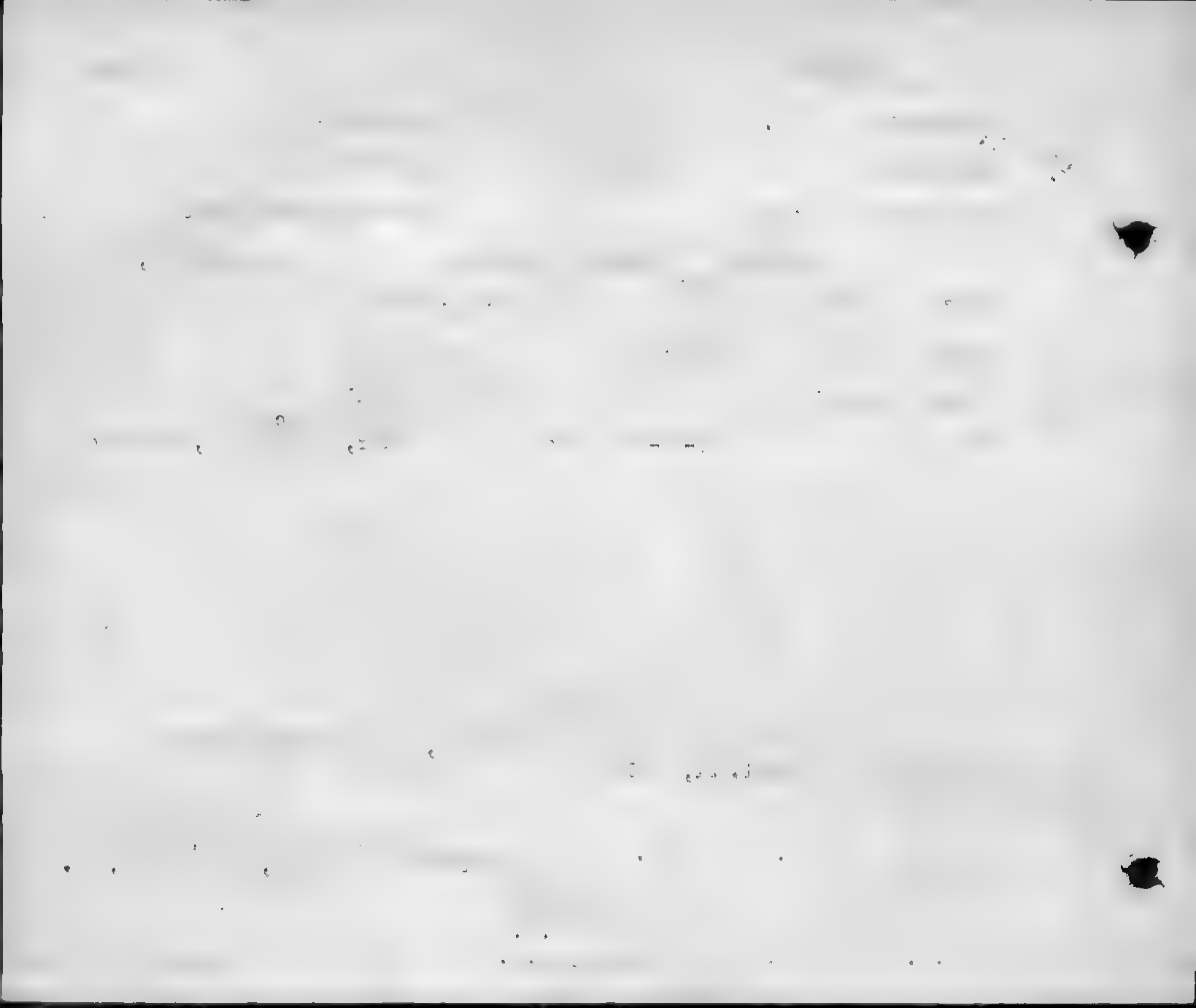
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10365

## CERTIFICATE OF DEATH

10360

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY in b<br><b>36 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><b>The Clinical Center</b> |                                  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><b>Pennsylvania</b><br>b. COUNTY<br><b>Shenandoah</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>112½ West Laurel Street</b><br>d. STREET ADDRESS<br><b>112½ West Laurel Street</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ANTHONY GISMIR GLADSKI</b>  |                                  | 4. DATE OF DEATH<br><b>September 21, 19 61</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>August 4, 1913</b> |
| 9. AGE (in years last birthday)<br><b>48 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours M'n.   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Miner</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Stephen Gladski</b>  |                                  | 14. MOTHER'S M.A.DEN NAME<br><b>Bertha Makowski</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>205-05-0257</b>   |   |
| 17. INFORMANT<br><b>The Medical Record</b>   |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br><b>3. 1. X</b><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>thrombotic shock</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>epidural and subdural hematoma</b><br>DUE TO<br>(c) <b>hematoma</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>INTERVAL BETWEEN ONSET AND DEATH</b> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August 16, 1961</b> to <b>September 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>Sept. 21, 1961</b> , and that death occurred at <b>11:30AM</b> from the causes and on the date stated above.                               |                                  | 22a. SIGNATURE<br><b>James C. Davie</b><br>22c. PHYSICIAN'S NAME (Type)<br><b>James C. Davie M.D.</b>   |   |
| 22b. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>  |                                  | 22d. DATE<br><b>9-21-61</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal 9/22/61</b>  |                                  | 23b. DATE THEREOF<br><b>9/22/61</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Casimirs Cem.</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Shenandoah, Pa.</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H. Hines Co. Washington 9, D.C.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>SEP 25 '61</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knecht</b>  |                                  | 25c. DATE<br><b>SEP 25 '61</b>  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10366

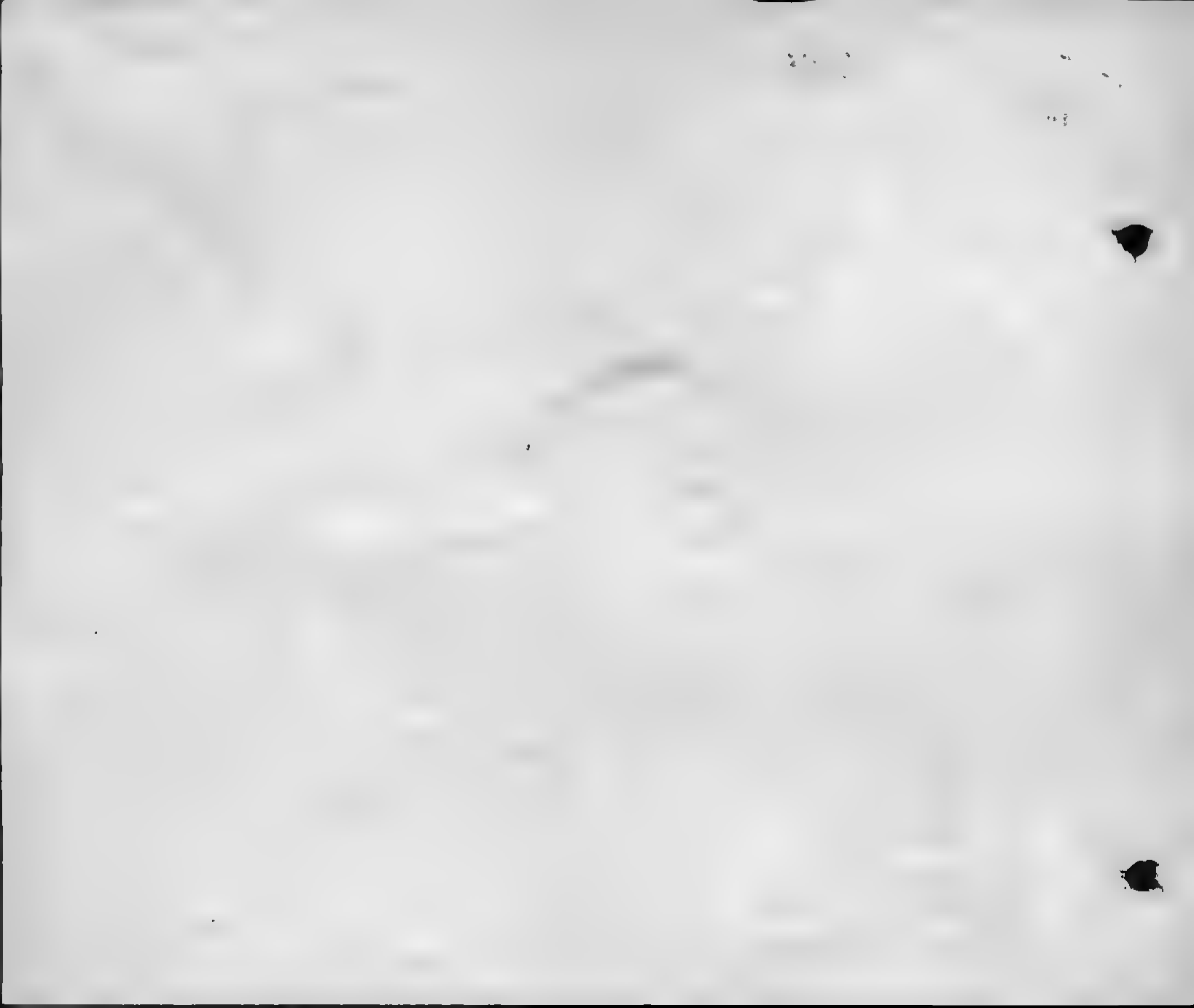
## CERTIFICATE OF DEATH

10361

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>1</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>d. STREET ADDRESS <u>1 5807 JARVIS LANE</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Anthony Francis</u> First Middle Last<br><b>5 SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>4. DATE OF DEATH</b> <u>Sept. 10 1961</u><br><b>8. DATE OF BIRTH</b> <u>JAN. 30, 1913</u> <b>9. AGE</b> (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR Months <u>9</u> Days <u>10</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mechanical Inspector</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N.I.H.</u><br><b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Pennsylvania</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>                                   |  | <b>13. FATHER'S NAME</b> <u>Nicholas Grasso</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>MARY S. Merolia</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 16-24-42 - 12-1945</u><br><b>16. SOCIAL SECURITY NO.</b> <u>166-05-2768</u><br><b>17. INFORMANT</b> <u>Dorothea S. Grasso</u> (Wife) Address <u>(SAME AS ABOVE)</u>    |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MALIGNANT CACHEXIA</u><br><u>200.2</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>LYMPHOMA, MALIGNANT, SCLEROSING</u><br>(c), stating the underlying cause last. DUE TO <u>14 MONTHS</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).<br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>AUG. 25, 1955, to SEPT. 10, 1961</u> , that (I) <u>(yes)</u> last saw the deceased alive on <u>SEPT. 9, 1961</u> , and that death occurred at <u>1:32 A.M.</u> from the causes and on the date stated above  |  |   |  |
| <b>22a. SIGNATURE</b> <u>Robert H. Angle</u><br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert H. Angle</u>   |  | <b>22b. DATE SIGNED</b> <u>SEPT. 10, 1961</u><br><b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b> <u>5009 Del Ray Ave. Bethesda, Md.</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  | <b>23b. DATE THEREOF</b> <u>9/13/61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nt. Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Virginia</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u> <b>ADDRESS</b> <u>Bethesda, Maryland</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>SEP 14 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hanna</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60





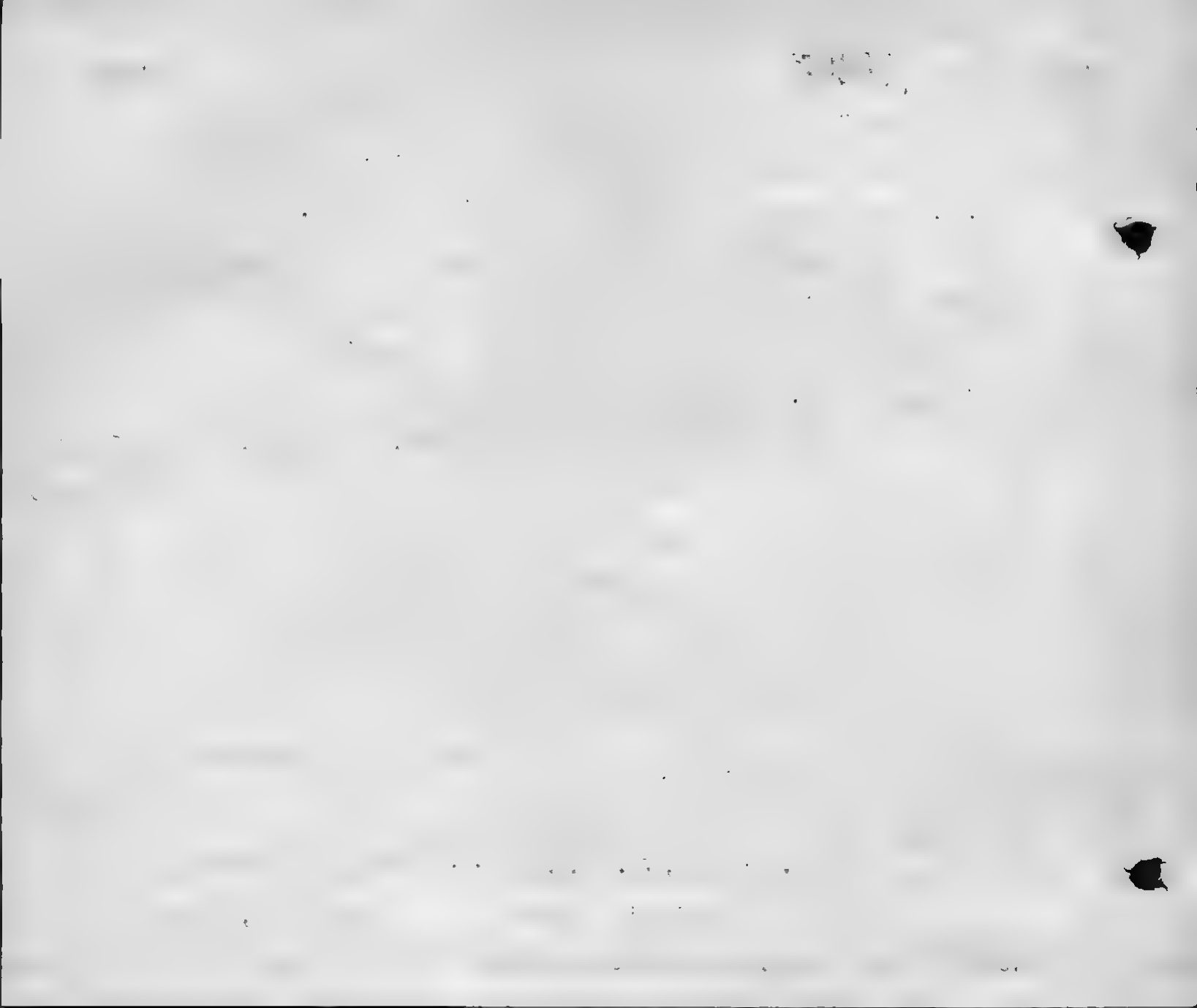
CERTIFICATE OF DEATH

10367

10362

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN 1b <u>12 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Florida</u> b. COUNTY _____<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Miami Beach</u><br>d. STREET ADDRESS <u>19665 NE 12th Ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Douglas Glen HALE</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>September</u> Day <u>23</u> Year <u>19 61</u>   |  |
| <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>August 3, 1944</u><br><b>9. AGE</b> (In years last birthday) <u>17 yrs.</u> <b>F UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS</b> Hours _____ Min. _____   |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |  |
| <b>13. FATHER'S NAME</b> <u>Clarence R. Hale</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Evelyn O'Roark</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) _____ <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> (Mother) <u>Mrs. Evelyn HALE, Same as #2 above</u>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>uremia</u><br>600.0 DUE TO _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>chronic pyelonephritis</u><br>DUE TO <u>neurogenic bladder</u><br>(c) _____<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2+ months</u><br><u>? 3 yrs.</u><br><u>17 yrs.</u>   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year: _____ Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____  |  | <b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 11 1961</u> to <u>September 23 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 23 1961</u> and that death occurred <u>7:45 AM</u> from the causes and on the date stated above.  |  |
| <b>22a. SIGNATURE</b> <u>John W. Brackett, Jr.</u> <b>22b. DATE SIGNED</b> <u>September 23, 1961</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>John D. Brackett, Jr. M.D.</u> <b>22d. ADDRESS</b> <u>U.S. Naval Hospital, Bethesda, Md</u>   |  | <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL - Shipment 9-23-61</u> <b>23b. DATE THEREOF</b> _____ <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Smithville Cemetery</u> <b>23d. LOCATION</b> (City, town or county) <u>Smithville, Georgia</u> (State) _____  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Humphrey</u> <b>25a. REC'D BY REGISTRAR</b> <u>SEP 26 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



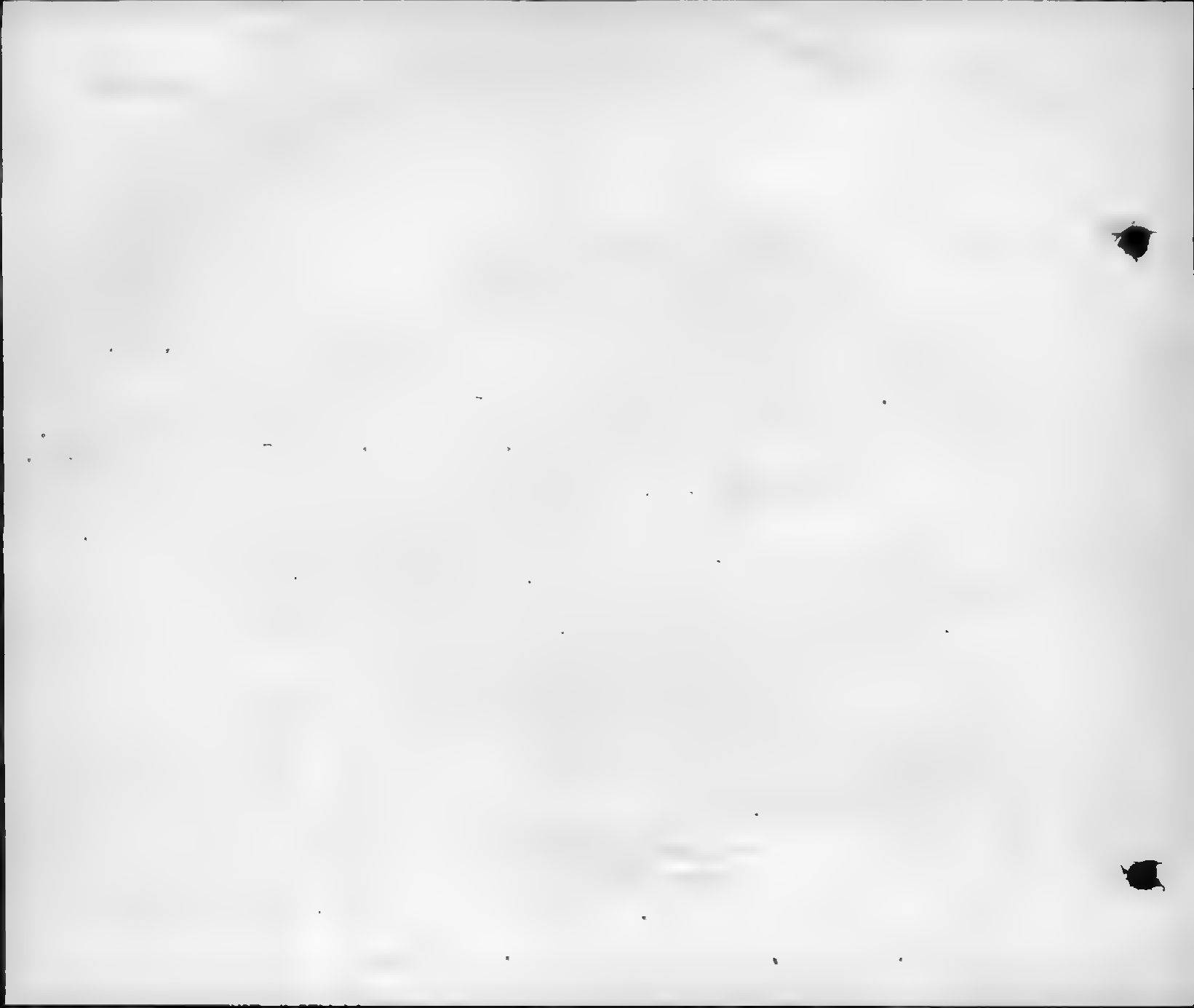
TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10368

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |                                  |   |                                       |   |  |   |  |
|--|----------------------------------|---|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>   |                                  |   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Mar Park</b>   |                                  |   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Mar Park</b>                                      |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>5301 Carlton Street</b>   |                                  |   |                                       | e. STREET ADDRESS<br><b>5301 Carlton Street</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cora</b> Middle <b>Annette</b> Last <b>Hammack</b>   |                                  |   |                                       | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>13</b> Year <b>1961</b>   |  |   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/28/1879</b> | 9. AGE (In years last birthday)<br><b>81</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min <b>13</b> | IF UNDER 24 HRS<br>Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min <b>13</b>  | IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>James S. Larrick</b>   |                                  |   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>----- Showater</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>no</b>  |                                       | 17. INFORMANT<br><b>Mrs. Robert E. Leahy</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>DUE TO <b>coronary sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last<br>(b) <b>generalized arteriosclerosis</b><br>(c) <b>Had fresh myocardial infarction 9 weeks ago</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Had fresh myocardial infarction 9 weeks ago</b> |                                  |   |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>3 years</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1958</b> to <b>present</b> , that (I) (we) last saw the deceased alive on <b>9-13-1961</b> , and that death occurred on <b>9-13-1961</b> M. from the causes and on the date stated above.   |                                  |   |                                       |   |  |   |  |
| 22a. SIGNATURE<br><b>C. P. Ryland</b>  |                                  |   |                                       | 22b. DATE SIGNED<br><b>Feb 1958</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>C. P. RYLAND, M.D.</b><br><b>4400 - 49th St., N. W.</b><br><b>Washington 16, D. C.</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/16/61</b>   |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Middletown, Virginia</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H.Hines Co.</b>   |                                  |   |                                       | 25a. REC'D BY REGISTRAR<br><b>SEP 15 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10369

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>40 SILVER SPRING</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  | d. STREET ADDRESS<br><u>12423-DEXTER AVE</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HARVEY</u> Middle <u>J.</u> Last <u>HARDING</u>  |                                  | 4. DATE OF DEATH<br>Month <u>SEPT</u> Day <u>13</u> Year <u>1961</u>  |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 18 1901</u> |
| 9. AGE (In years last birthday)<br><u>60</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>10</u> Hours <u>10</u> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Technician—Sears &amp; Roebuck</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Willie Harding</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Ida Harding</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO<br><u>577-05-8980</u>  |  |
| 17. INFORMANT<br><u>Magdalene Harding (wife)</u>   |                                  | Address<br><u>2423 DEXTER AVE Silver Spring</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion—Myocardial Infarction</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>9/8/61</u> , 19____, to <u>9/13/61</u> , 19____, that I last saw the deceased alive on <u>9/13/61</u> , 19____, and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE<br><u>R. L. Taylor, M.D.</u>  |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>13000 GEORGIA AVE. S.S. Md.</u>   |  |
| PHYSICIAN'S NAME (Type)<br><u>S. L. TABB, M.D.</u>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF<br><u>9-16-61</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cem.</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Washington D.C.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Timothy Haulan</u>  |                                  | ADDRESS<br><u>3831 14th St N.W. D.C.</u>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 20 '61</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hanes</u>  |  |

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10370

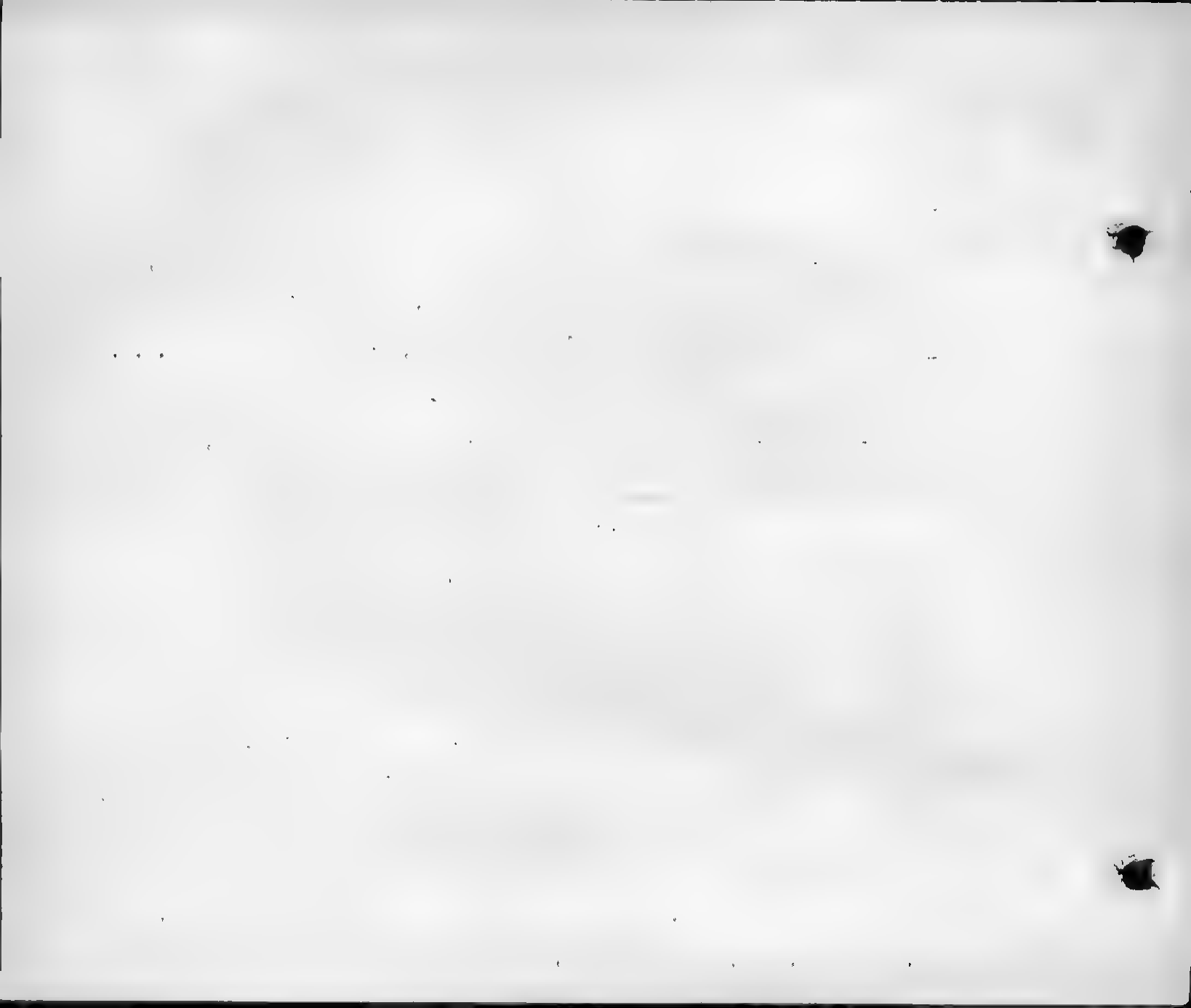
10365

10370

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b><br>c. LENGTH OF STAY IN 1b<br><b>4 days</b><br>d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION<br><b>Althea Woodland</b>   |                                 | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b><br>d. STREET ADDRESS<br><b>3119 McComas Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Paulah Fawcett Hardy</b>   |                                 | 4 DATE OF DEATH<br>Month Day Year<br><b>September 14 1961</b>  |  |
| 5. SEX<br><b>Female</b>   | 6 COLOR OR RACE<br><b>white</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>November 6, 1878</b> |
| 9 AGE (in years lost birthday)<br><b>82 yrs</b>   |                                 | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>92</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School Teacher</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Montgomery Co.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Fairland, Maryland</b>  |                                 | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Edward Lloyd Fawcett</b>  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Ellie Marlow</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                 | 16 SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17 INFORMANT<br><b>Miss Catherine Hardy</b>   |                                 | Address<br><b>3119 McComas Avenue Kensington, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocardial Degeneration</b><br>DUE TO (c) <b>Generalized arteriosclerosis</b> |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Mo.</b><br><b>years</b><br><b>"</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                 | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)   |  |
| 21 I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>4/22 1959</b> to <b>9/14 1961</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9/10 1961</b> , and that death occurred at <b>7:50 A.</b> from the causes and on the date stated above   |                                 |  |  |
| 22a. SIGNATURE<br><b>Merrill M. Cross</b> M.D.  |                                 | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/><br>22d. ADDRESS<br><b>8248 Kensington Ave. Silver Spring, Maryland</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MERRILL M. CROSS M.D.</b>  |                                 | 22b. DATE SIGNED<br><b>9/14/61</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b. DATE THEREOF<br><b>9/16/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Cemetery</b>  |                                 | 23d. LOCATION (City, town, or county) (State)<br><b>Montgomery County, Maryland</b>  |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE<br><b>Walter E. Pumphrey, Inc.</b>  |                                 | 25a. REC'D BY REGISTRAR<br><b>SEP 19 61</b>  |  |
| ADDRESS<br><b>8434 Georgia Avenue Silver Spring, Maryland</b>   |                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>   |  |





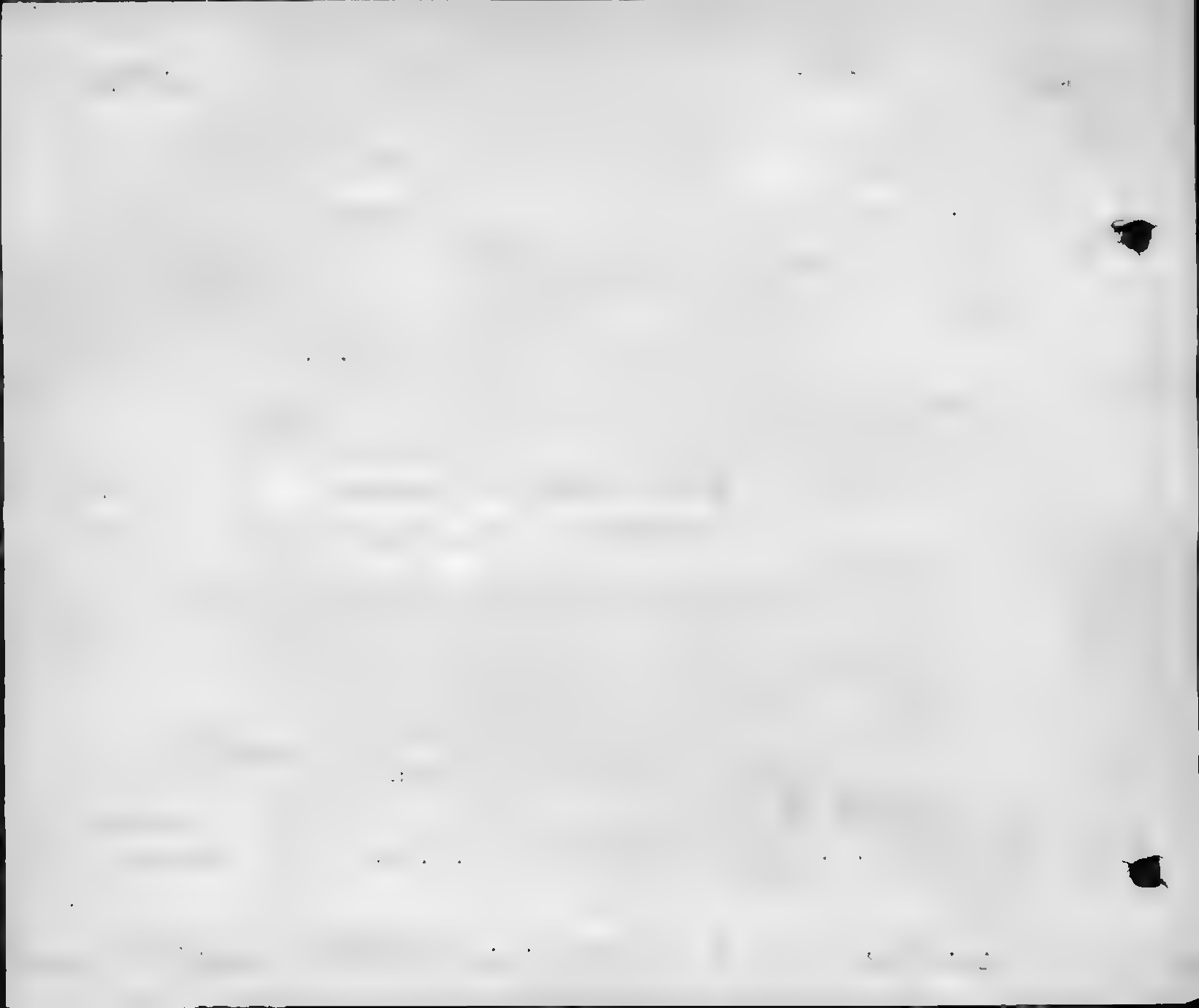
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A13 (4)  
15M 9/60

1  
M  
10371  
10366  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |  |  |   |                                       |  |
|---|--|--|---|---------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)<br>c. LENGTH OF STAY IN b<br>115 days<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U. S. Naval Hospital  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Hyattsville<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Hyattsville<br>d. STREET ADDRESS<br>3000 Lancer Drive<br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>William Francis HART<br>4. DATE OF DEATH<br>Month Day Year<br>September 12 19 61   |  |  | 5. SEX<br>Male<br>6. COLOR OR RACE<br>Caucasian<br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH<br>2-14-97<br>9. AGE (in years last birthday)<br>64 yrs.<br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                             |                                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Guard<br>10b. KIND OF BUSINESS OR INDUSTRY<br>Art Gallery<br>11. BIRTHPLACE (County & State or foreign country)<br>Washington, D. C.<br>12. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 13. FATHER'S NAME<br>Patrick J. Hart<br>14. MOTHER'S MAIDEN NAME<br>Katherine Collins  |   |                                       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes WW I<br>16. SOCIAL SECURITY NO.<br>578 01 4776<br>17. INFORMANT<br>(W) Lucy M. Hart Same as #2 above<br>Address  |  | 18. CAUSE OF DEATH (Enter only one cause part or for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) DUE TO<br>111X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>Spinal cord compression<br>Metastatic Carcinoma Lung<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br>1 WK<br>1 yr - |   |                                       |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |                                       |  |
| 21. I certify that (this hospital) attended the deceased from May 20 19 61 to September 12 19 61 that I (we) last saw the deceased alive on September 12 19 61, and that death occurred at 8:10 AM from the causes and on the date stated above.  |  |  |   |                                       |  |
| 22a. SIGNATURE<br>R. W. MACKIE, CAPT MC USN<br>22c. PHYSICIAN'S NAME (Type)<br>R. W. MACKIE, CAPT MC USN  |  | M.D.<br>22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.  |   | 22b. DATE SIGNED<br>12 September 1961 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial<br>23b. DATE THEREOF<br>14 Sept 1961<br>23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National<br>23d. LOCATION (City, town or county)<br>Arlington<br>(State)<br>Va.   |  | 24. FUNERAL DIRECTOR'S SIGNATURE<br>S. H. HINES, 2901 14th St. Washington, D. C.<br>25a. REC'D BY REGISTRAR<br>DATE SEP 14 '61<br>25b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus  |   |                                       |  |

The S.H. Hines Co. 2901 14th St. W. D.C.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN

14 hours 30 min

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanatorium & Hospital

3. NAME OF DECEASED (Type or print)

Robert

James

Haslam

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

August 14, 1944

9. AGE (in years; last birthday)

17 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert E Haslam

14. MOTHER'S MAIDEN NAME

Ruth McKenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

NO

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).

911.5

DOE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

DOE TO

MASSIVE HEMORRHAGE INTO THE RT. CEREBELLAR HEMISPHERE AND ADJACENT PONS AND MIDBRAIN MULTIPLE SKULL FRACTURES

INTERVAL BETWEEN ONSET AND DEATH

14 hrs. 30 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

MASSIVE VASCULAR ENGORGEMENT OF BOTH LUNGS

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

3:20 p.m.

Month, Day, Year

9-23-61

20d. INJURY OCCURRED

While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

8544-16 St

20f. (City or town)

Silver Spring monty md

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschant

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9-24-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/27/61

22c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery

22d. LOCATION (City, town, or country)

Prince George's County, Maryland

(State)

23. FUNERAL DIRECTOR

Warner E. Pumphrey, Inc.

ADDRESS

8434 Georgia Avenue

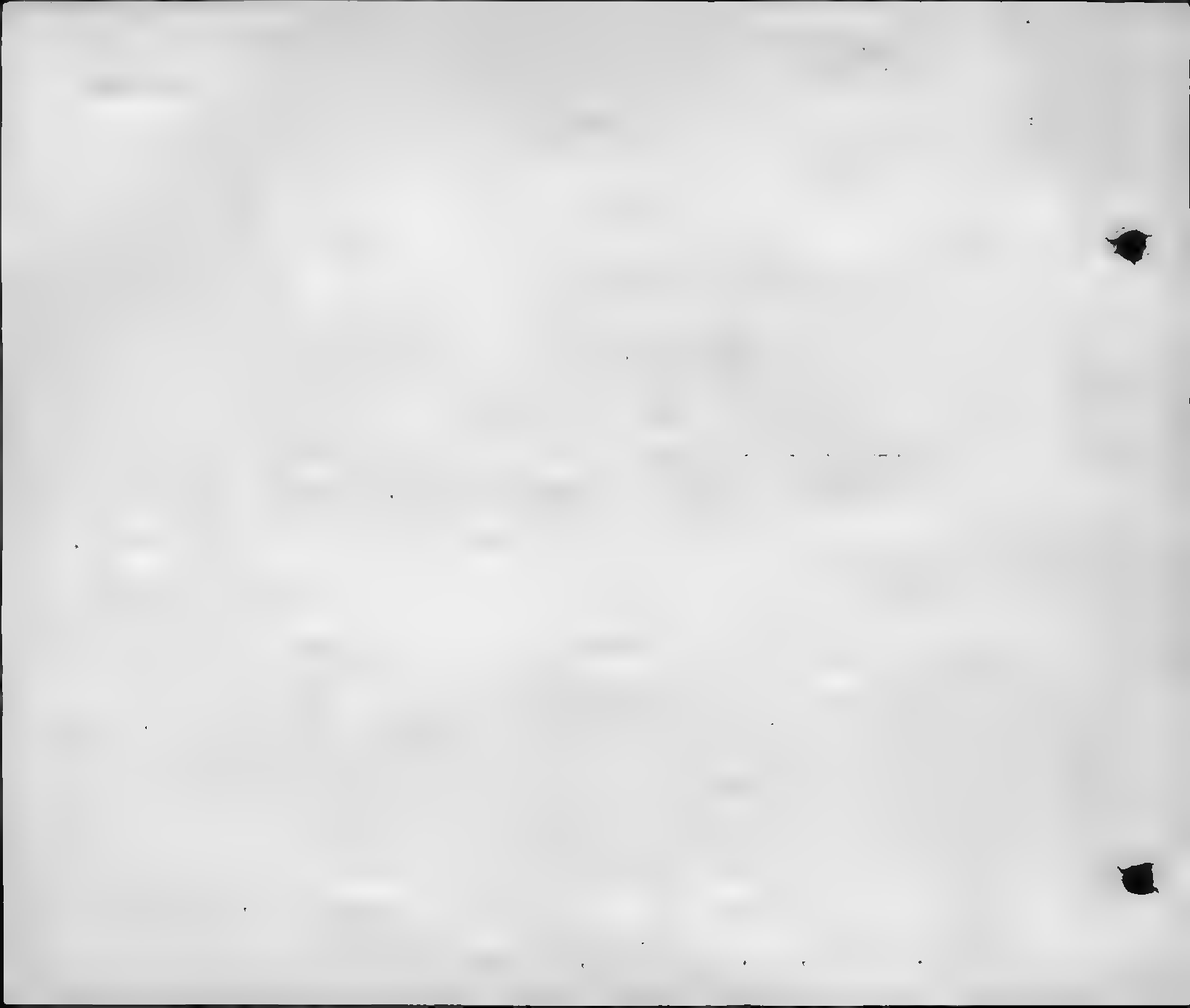
24a. REC'D BY REGISTRAR

SEP 26 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

1. JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

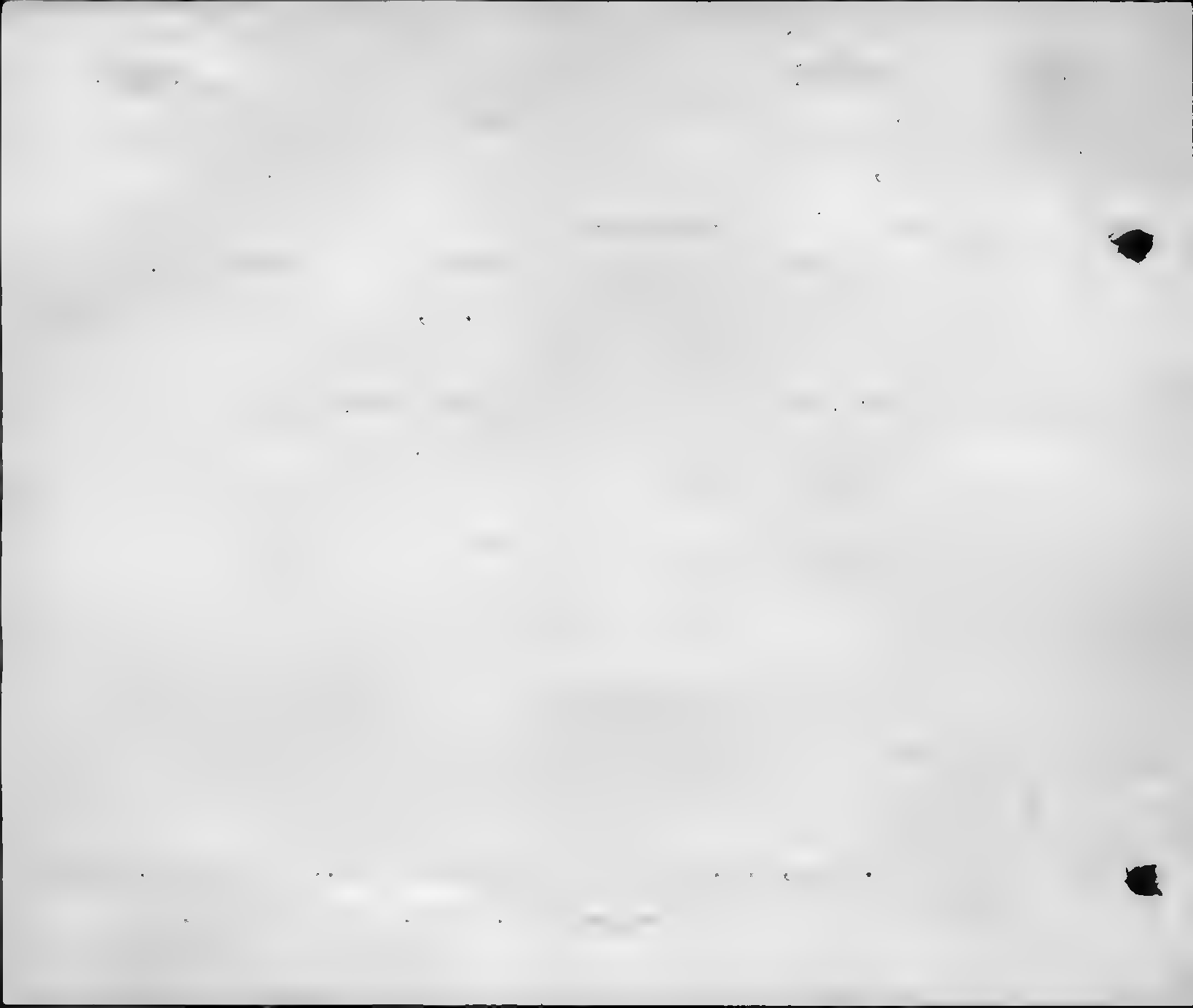


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

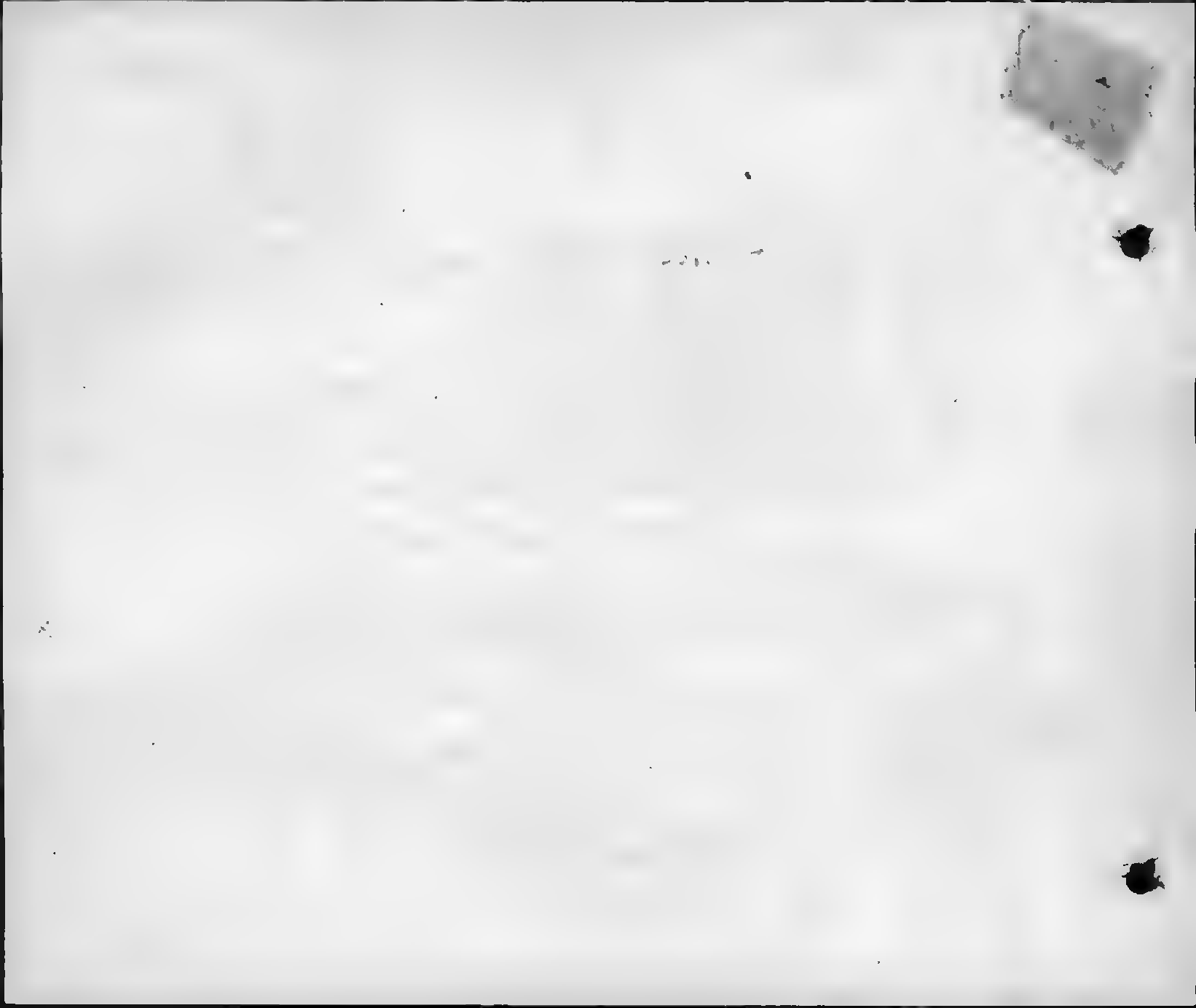
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C  
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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |
| 10373  |  |  |  |  |  | 10368   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park,</b><br>c. LENGTH OF STAY IN b.<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington Sanitarium and Hospital</b>  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring,</b><br>d. STREET ADDRESS<br><b>2615 Elnora Street</b> |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Baby Boy Hawkins</b>  |  |  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>September 29, 19 61</b>  |  |  |  |  |  |
| 5. SEX<br><b>Male</b>  |  |  |  |  |  | 6. COLOR OR RACE<br><b>White</b>  |  |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>   |  |  |  |  |  | 8. DATE OF BIRTH<br><b>Sept. 29, 1961</b>   |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  |  |  | 9. AGE (in years last birthday)<br>IF UNDER 1 YEAR: Months Days Hours Min<br><b>40</b>  |  |  |  |  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  | 11. BIRTHPLACE (County & State or foreign country)  |  |  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  | 13. FATHER'S NAME<br><b>Richard Earl Hawkins</b>  |  |  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>China Victoria Maltba</b>   |  |  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |  |  |  |  |
| 16. SOCIAL SECURITY NO.  |  |  |  |  |  | 17. INFORMANT<br><b>father</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), (b) and c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>161.5 Atelectasis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br><b>Pneumatury</b><br>(c), stating the underlying cause last,<br><b>Pneumonia Right Middle Lobe</b><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month. Day. Year<br>Hour a.m. p.m.<br><b>19</b>   |  |  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  |  | 20f. (City or town) (County) (State)  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/27, 1961</b> to <b>9/29, 1961</b> , that (I) (we) last saw the deceased alive on <b>9/29, 1961</b> , and that death occurred at <b>11:59 AM</b> , from the causes and on the date stated above.   |  |  |  |  |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Raymond F. Chinn, M.D.</b>  |  |  |  |  |  | 22b. DATE SIGNED<br><b>9/29/61</b>  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Raymond F. Chinn, M.D.</b>  |  |  |  |  |  | 22d. ADDRESS<br><b>1110 Spring St., Silver Spring, Maryland</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>  |  |  |  |  |  | 23b. DATE THEREOF<br><b>October 1, 61</b>   |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington San. &amp; Hosp.</b>   |  |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Takoma Park, Md.</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DATE OCT 4 '61</b>  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>  |  |  |  |  |  |   |  |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND   |                               |   |   |  |   |                    |  |                 |  |
|---|-------------------------------|---|---|--|---|--------------------|--|-----------------|--|
| 10374   |                               |   |   |  | 10369   |                    |  |                 |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b><br>c. LENGTH OF STAY IN 1b <b>25 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b> |                               |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>d. STREET ADDRESS <b>14402 Bywood Lane</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    |  |                 |  |
| 3. NAME OF DECEASED<br>(Type or print)  |                               |   | First Middle Last                             |  |   | 4. DATE OF DEATH   |  | Month Day Year  |  |
| <b>Constance</b>  |                               |   | <b>Mary</b>                                   |  |   | <b>SEPT.</b>       |  | <b>6, 1961</b>  |  |
| 5 SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <b>12/25/1885</b>             |  | 9 AGE (In years last birthday) <b>75</b> yrs  | 10 IF UNDER 1 YEAR |  | IF UNDER 24 HRS |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <b>Housewife</b>  |                               |   | 10b KIND OF BUSINESS OR INDUSTRY <b>-----</b> |  | 11 BIRTHPLACE (State or foreign country) <b>England</b>   |                    | 12 CITIZEN OF WHAT COUNTRY? <b>England</b> |                 |  |
| 13. FATHER'S NAME <b>John Smith.</b>  |                               |   |   |  | 14. MOTHER'S MAIDEN NAME <b>Eliza Mary Cooper</b>   |                    |  |                 |  |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes, give war or dates of service)  |                               |   | 16 SOCIAL SECURITY NO. <b>None</b>            |  | 17. INFORMANT <b>John G. Morris, son-in-law-same 2d</b> Address   |                    |  |                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]   |                               |   |   |  |   |                    |  |                 |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>  |                               |   |   |  |   |                    |  |                 |  |
| 331X DUE TO <b>Arteriosclerosis.</b>  |                               |   |   |  |   |                    |  |                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)   |                               |   |   |  |   |                    |  |                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsons Disease.</b>  |                               |   |   |  |   |                    |  |                 |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |   |  |   |                    |  |                 |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |   |  |   |                    |  |                 |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                               |   |   |  |   |                    |  |                 |  |
| 20c. TIME OF INJURY Month. Day Year Hour a m p m <b>19</b>  |                               |   |   |  |   |                    |  |                 |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                               |   |   |  |   |                    |  |                 |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               |   |   |  |   |                    |  |                 |  |
| 20f. (City or town) (County) (State)  |                               |   |   |  |   |                    |  |                 |  |
| 21 I certify that (I) (this hospital) attended the deceased from <b>8/28/61</b> to <b>9/6/61</b> , that (I) (we) last saw the deceased alive on <b>9/6/61</b> and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above  |                               |   |   |  |   |                    |  |                 |  |
| 22a. SIGNATURE <b>Charles J. Everding M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>9/6/61</b>   |                               |   |   |  |   |                    |  |                 |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Charles J. Everding MD</b> 22d. ADDRESS <b>4401 East West High Bldg.</b>  |                               |   |   |  |   |                    |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b> 23b. DATE THEREOF <b>9/11/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b> 23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>  |                               |   |   |  |   |                    |  |                 |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b> 25a. REC'D BY REGISTRAR <b>SEP 14 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>  |                               |   |   |  |   |                    |  |                 |  |



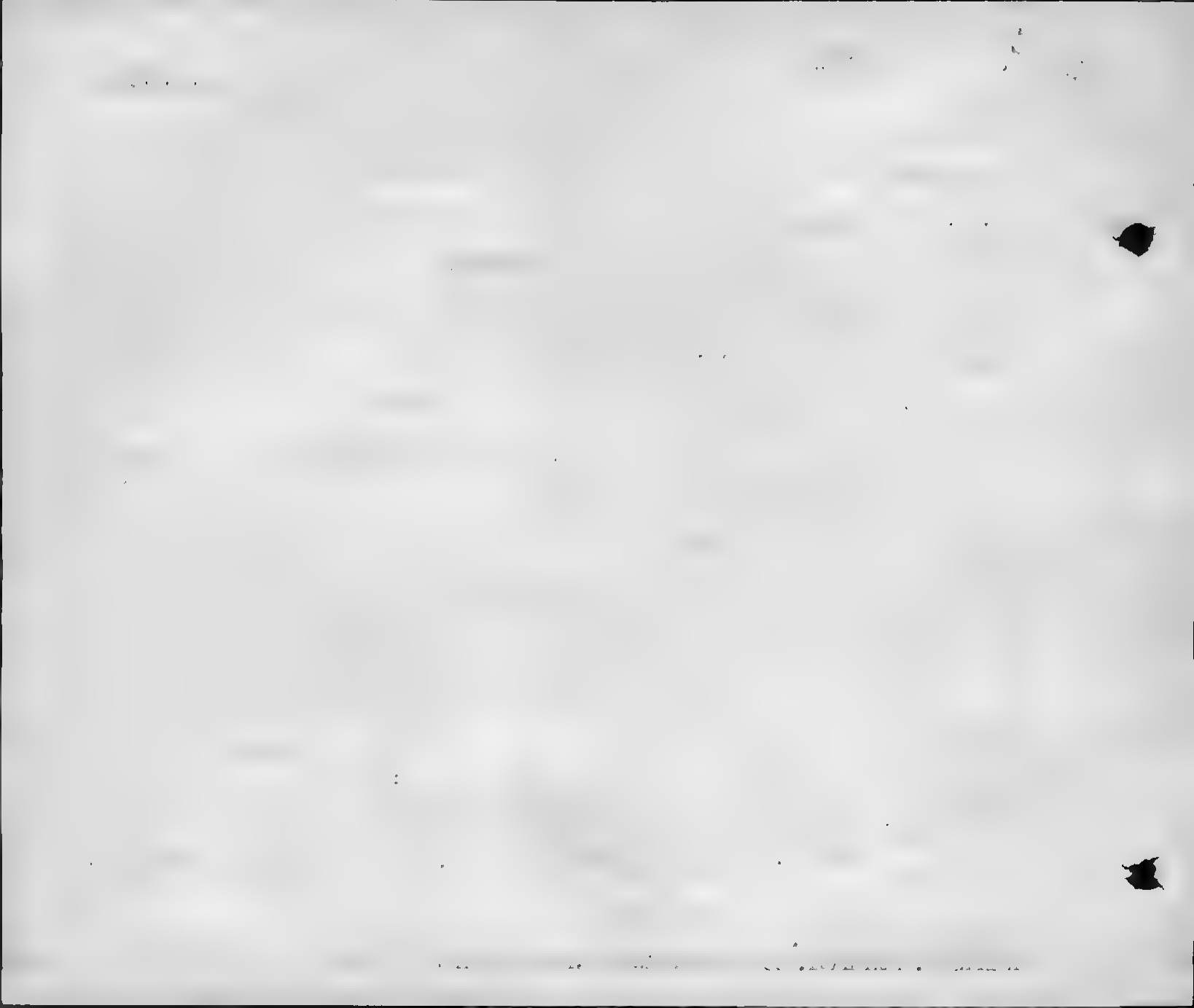


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |
| 10375 CERTIFICATE OF DEATH 10370   |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>a. STATE<br>Pennsylvania<br>b. COUNTY<br>Philadelphia<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Philadelphia<br>d. STREET ADDRESS<br>4052 Chestnut St. |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |  |  |  | c. LENGTH OF STAY IN 1b<br>3 days  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>U. S. Naval Hospital   |  |  |  | F. 1st Middle Last<br>Roger Lee Heacock  |  |  |  | 4. DATE OF DEATH<br>September 21 1961  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Male   |  |  |  | 6. COLOR OR RACE<br>Caucasian  |  |  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 5. SEX<br>Male   |  |  |  | 8. DATE OF BIRTH<br>12-7-06  |  |  |  | 9. AGE (in years last birthday)<br>54 yrs.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Consul  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Government   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Iowa  |  |  |  |
| 13. FATHER'S NAME<br>Charles Clement Heacock   |  |  |  | 14. MOTHER'S MAIDEN NAME<br>Eva Schaffer   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |  |  |  | 16. SOCIAL SECURITY NO.<br>1   |  |  |  | 17. INFORMANT<br>(W) Marieluise Heacock Same as #2 above   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.0 VENTRICULAR fibrillation<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b) MYOCARDIAL infarction<br>DUE TO<br>(c) ARTERIOSCLEROTIC heart disease |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>2 weeks<br>16 years  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)<br>EMPYEMA  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19   |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (H) (this hospital) attended the deceased from Sept. 18, 1961, to Sept. 21, 1961, that (H) (we) last saw the deceased alive on Sept. 21, 1961, and that death occurred at 4:50 AM from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br>Vernon N. Houk   |  |  |  | 22b. DATE SIGNED<br>21 Sept 1961   |  |  |  | 22c. PHYSICIAN'S NAME (Type)<br>VERNON N. HOUK, LCDR MC USN  |  |  |  |
| 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.  |  |  |  | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  | 22f. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial-Shipment   |  |  |  | 23b. DATE THEREOF<br>22 Sept 1961  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>East Lawn  |  |  |  |
| 23d. LOCATION (City, town or county)<br>Swathmore  |  |  |  | 23e. (State)<br>Pa   |  |  |  | 23f. (State)   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Robert A. Pumphrey   |  |  |  | 24a. ADDRESS<br>7557 Wisconsin Ave, Bethesda Md.   |  |  |  | 24b. REC'D BY REGISTRAR<br>SEP 25 '61  |  |  |  |
| 24c. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus  |  |  |  | 24d. ADDRESS   |  |  |  | 24e. DATE  |  |  |  |



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

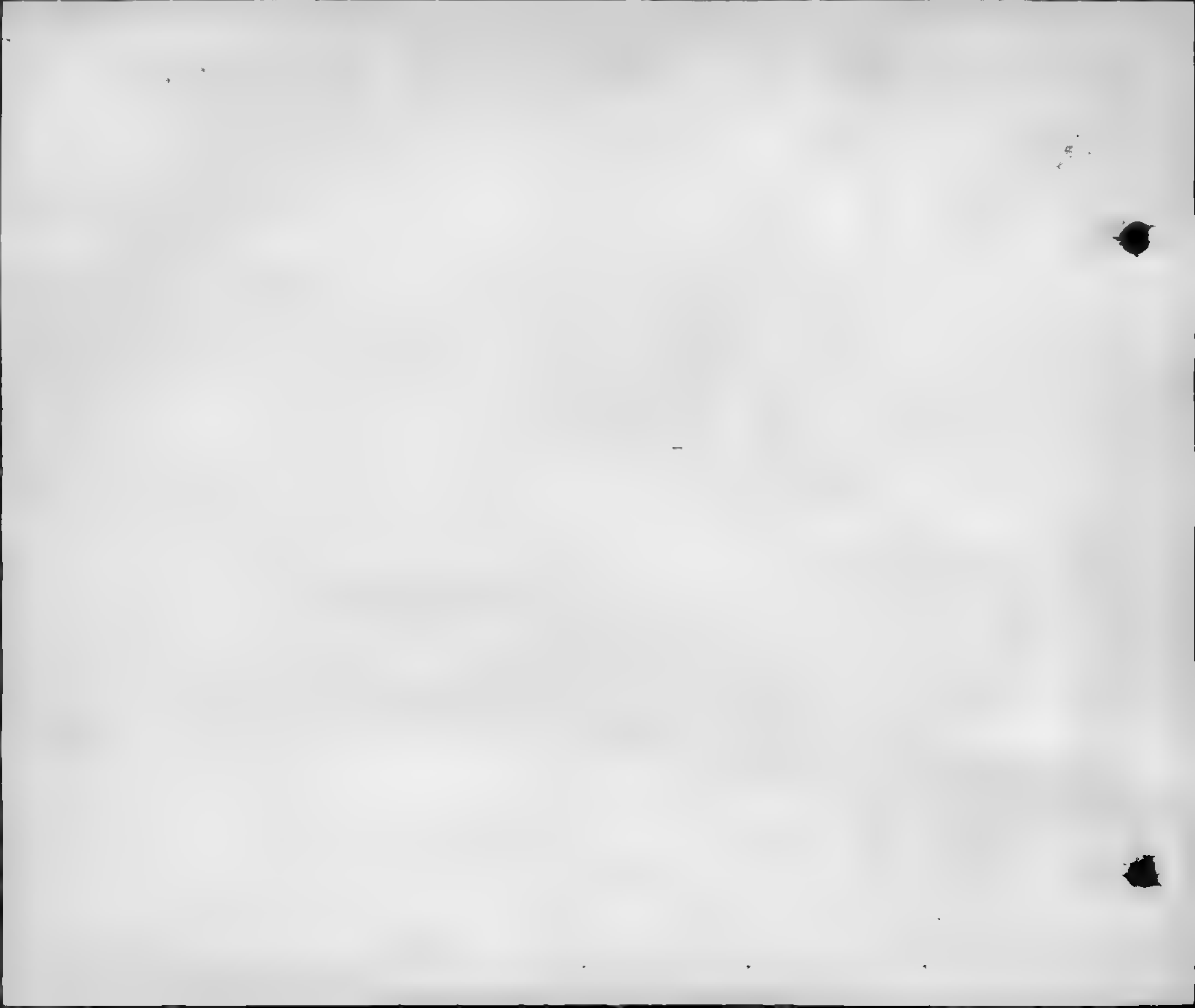
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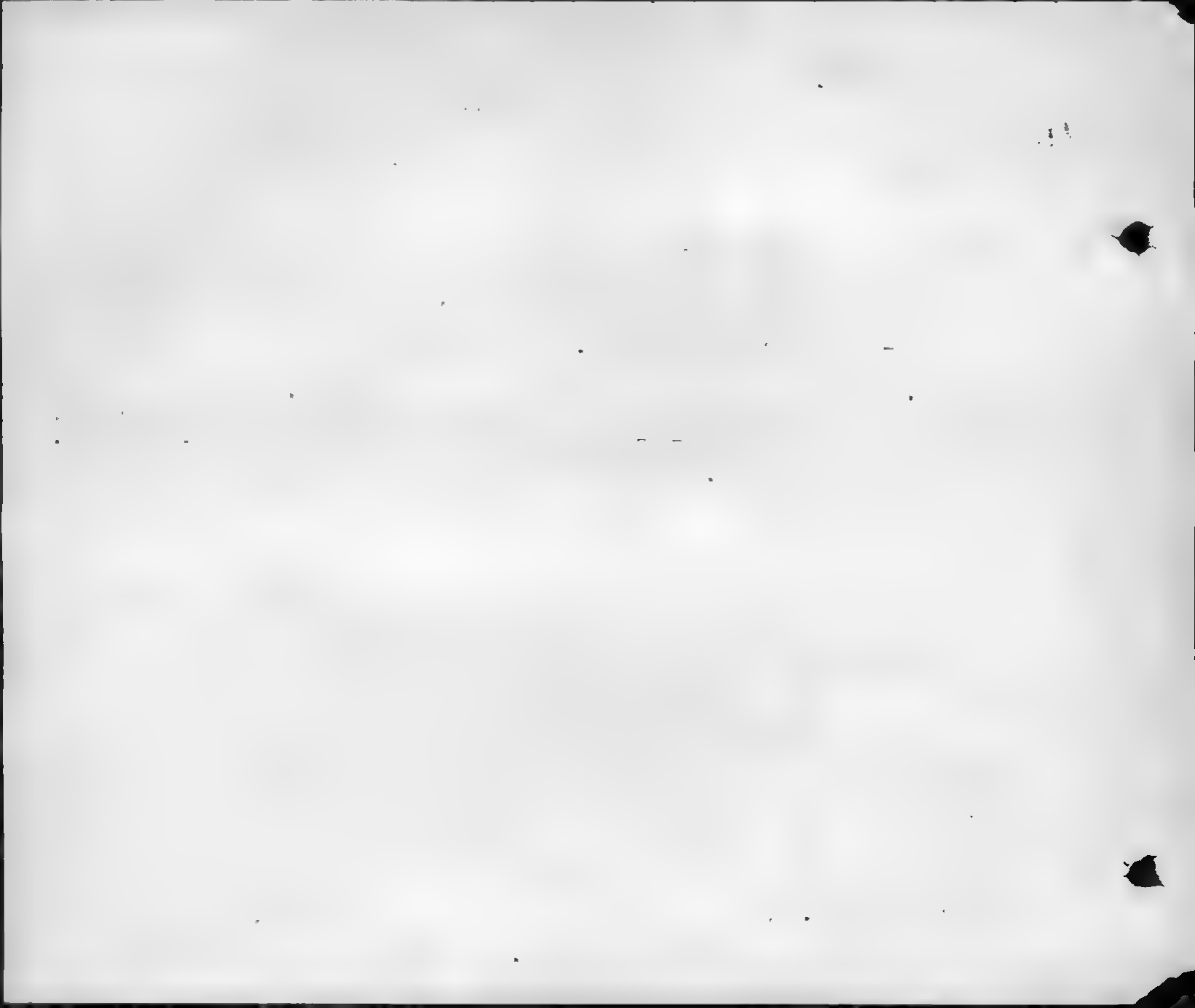
**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**10376 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10371**

|   |  |   |  |
|---|--|---|--|
| <p>1. PLACE OF DEATH<br/>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u></p> <p>c. LENGTH OF STAY IN TB <u>6 days</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hosp</u></p>   |  | <p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br/>e. STATE <u>md</u> f. COUNTY <u>Montg</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u></p> <p>d. STREET ADDRESS <u>11009 Notley Rd</u></p>   |  |
| <p>3. NAME OF DECEASED (Type or print) <u>William David Hecht</u></p> <p>5. SEX <u>male</u></p> <p>6. COLOR OR RACE <u>white</u></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>6-15-74</u></p> <p>9. AGE (In years last birthday) <u>87</u> yrs.</p>  |  | <p>4. DATE OF DEATH <u>Sept 14 1961</u></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Duplex Electric</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>N. Y.</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>  |  |
| <p>13. FATHER'S NAME <u>Elias Hecht</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)</p>   |  | <p>14. MOTHER'S MAIDEN NAME <u>Isabella Foster</u></p> <p>16. SOCIAL SECURITY NO. <u>064-17-5597</u></p> <p>17. INFORMANT <u>Hospital Record</u> Address</p>  |  |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a) <u>Bronch pneumonia</u><br/>DUE TO <u>163X</u><br/>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br/>DUE TO <u>C.A. of lung with metastasis</u><br/>(c) <u>Generalized atherosclerosis</u></p> <p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I<br/><u>Fracture of 7th rib - at.</u></p>   |  |   |  |
| <p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</p> <p>20c. TIME OF INJURY Month, Day, Year<br/>Hour e.m. <u>2</u> p.m. <u>8-21 1961</u></p>  |  | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br/><u>Fell in garden at home</u></p> <p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u></p> <p>20f. (City or town) <u>Silver Spring Montg md</u> (County) (State)</p> |  |
| <p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>Address (Street, city, town, or county) <u>9-14-61</u></p> |  |   |  |
| <p>ACTUAL SIGNATURE <u>Frank J. Brosch</u></p> <p>EXAMINER'S NAME (Type) <u>FRANK J. BROSCH</u></p>   |  | <p>DATE SIGNED <u>9-14-61</u></p>   |  |
| <p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u></p> <p>22b. DATE THEREOF <u>9/18/61</u></p>  |  | <p>22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u></p> <p>22d. LOCATION (City, town, or country) <u>Brooklyn New York</u></p>  |  |
| <p>23. FUNERAL DIRECTOR <u>Raymond A Ziska</u></p> <p>Address <u>2434 Georgia Avenue</u></p> <p><u>Barber 7, Pumphrey, Inc. Silver Spring, Maryland</u></p>   |  | <p>24b. REC'D BY REGISTRAR <u>SEP 19 '61</u></p> <p>24c. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u></p>  |  |







1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form F-103. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

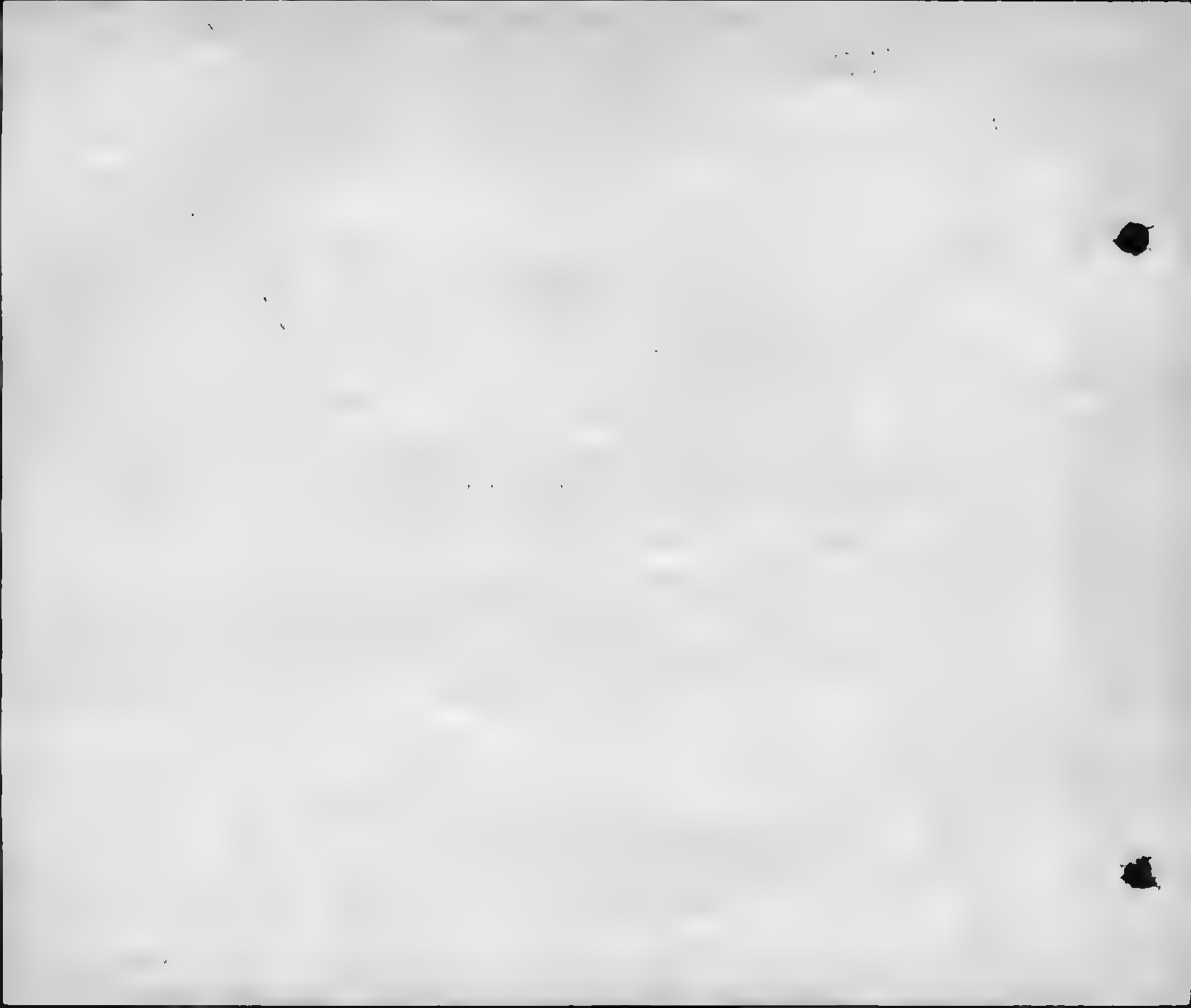
**10378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Item 14 Film G-94 9/8/61 iwk

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY in b 27 days  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hosp. 508 Albany Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print) John William Hite  
4. DATE OF DEATH 9/1/1961  
5. SEX Male  
6. COLOR OR RACE W  
7. MARRIED ☒ NEVER MARRIED ☐  
8. DATE OF BIRTH 6-14-74  
9. AGE (In years, if under 1 year, give months, days, hours, minutes) 87  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchants Transfer + Storage  
10b. KIND OF BUSINESS OR INDUSTRY Maryland  
11. BIRTHPLACE (State or foreign country) USA  
12. CITIZEN OF WHAT COUNTRY? USA  
13. FATHER'S NAME ISAAC Hite  
14. MOTHER'S MAIDEN NAME MARY ELIZABETH unknown  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  
16. SOCIAL SECURITY NO. Copied from Hosp. Chart  
17. INFORMANT Copied from Hosp. Chart  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute coronary insufficiency  
DUE TO (b) Severe coronary arteriosclerosis  
DUE TO (c) Fractures of the pelvis  
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: None  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.) Fell on floor at home.  
20c. TIME OF INJURY Month, Day, Year 3:10 a.m. 8/2 1961  
20d. INJURY OCCURRED While at work ☐ Not While at work ☒  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home  
20f. (City or town) Takoma Park Md. (County) P.G. (State) MD.  
21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE Frank J. Blaszczak M.D. CHIEF MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 9-2-61  
EXAMINER'S NAME (Type) FRANK J. BLASZCZAK  
Address (Street, city, town, or county)  
22a. BURIAL, CREMATION, or other disposal (Specify) Burial  
22b. DATE THEREOF Sept 1961  
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery  
22d. LOCATION (City, town, or country) Prince Geo. Co. Md.  
23. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St. WDC  
ADDRESS  
24a. REC'D BY REG STRAR SEP 5 '61  
24b. REGISTRAR'S SIGNATURE J. H. Hume





TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

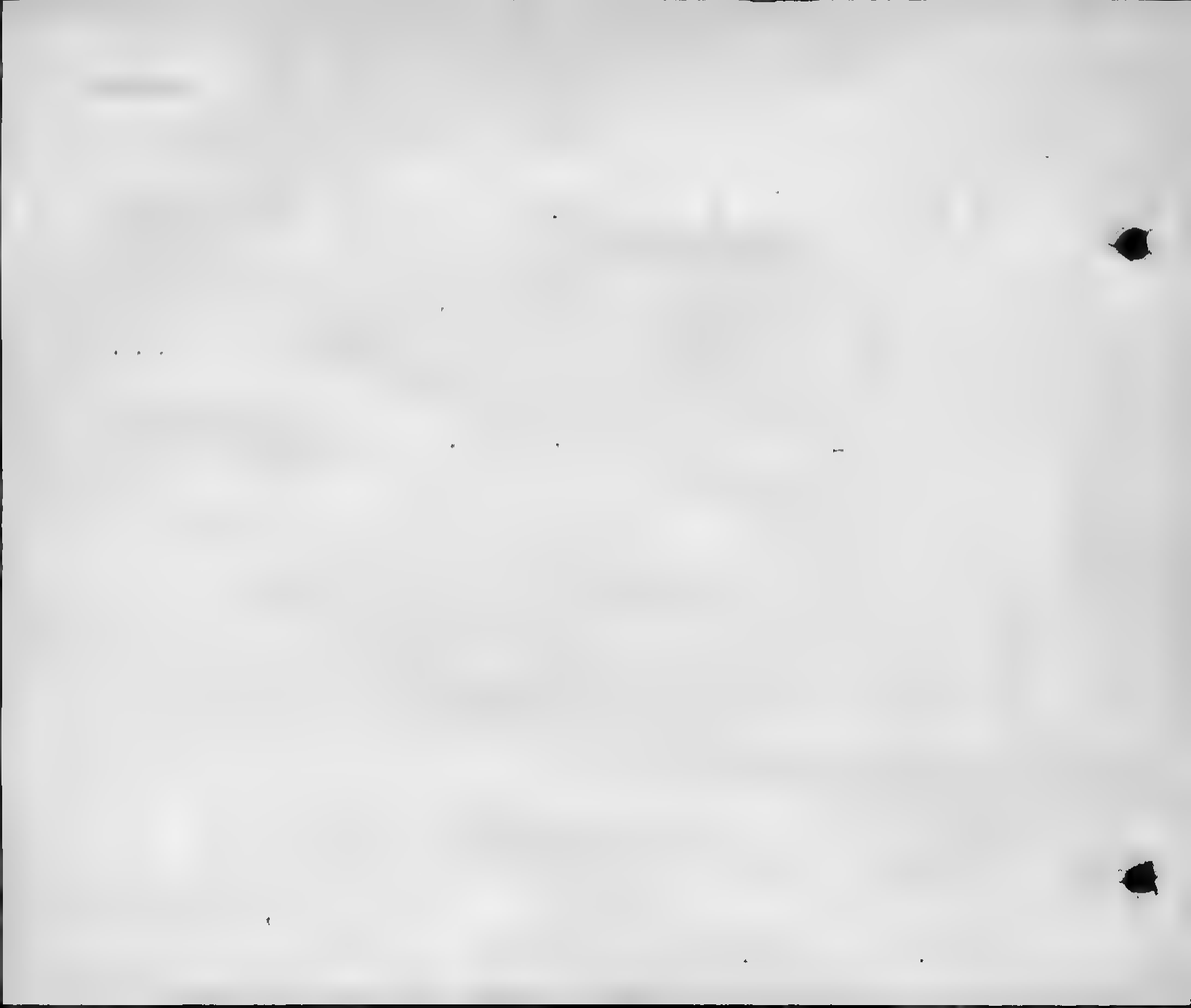
FOR STATE  
HEALTH DEPT.

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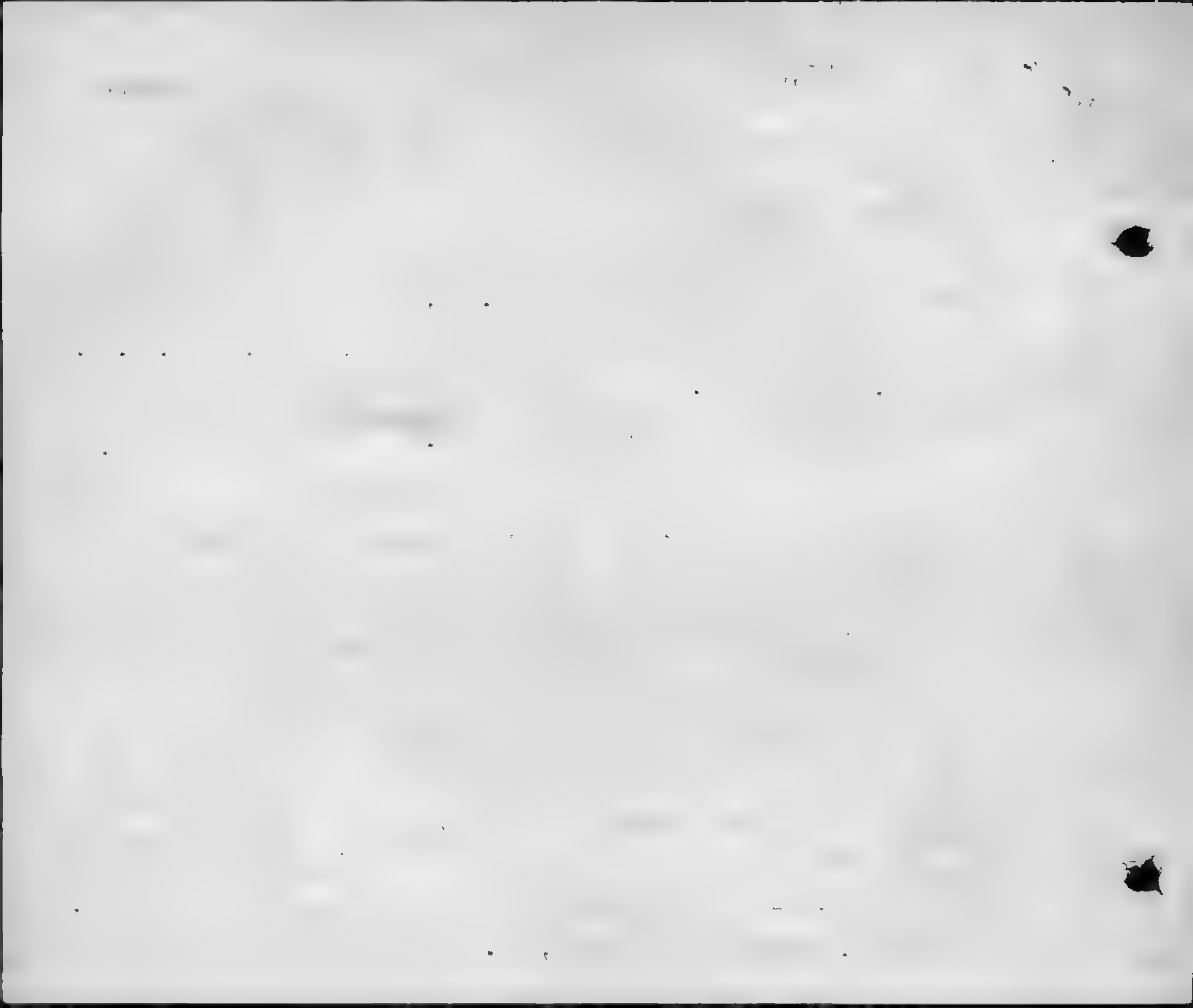
MEDICAL CERTIFICATION

| 1. PLACE OF DEATH  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, give address; if not, give address of nearest town)   |  |  |  |
|--|--|--|--|---|--|--|--|
| a. COUNTY<br>Montgomery  |  |  |  | b. COUNTY<br>Montgomery   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Takoma Park  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Washington Sanitarium + Hosp.  |  |  |  | d. STREET ADDRESS<br>757 Silver Spring Ave  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>ERNEST E. PAUL Hogman  |  |  |  | 4. DATE OF DEATH<br>9 24 1961   |  |  |  |
| 5. SEX<br>M  |  |  |  | 6. COLOR OR RACE<br>W   |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 8. DATE OF BIRTH<br>August 13, 1882   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Engineer  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Smithsonian Institute  |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Sweden  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |
| 13. FATHER'S NAME<br>Unknown   |  |  |  | 14. MOTHER'S MAIDEN NAME<br>Unknown   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br>Yes WWI                                     |  |  |  | 16. SOCIAL SECURITY NO.<br>25,928 Woodfield Road  |  |  |  |
| 17. INFORMANT<br>Mr. James E. Stephen's  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary occlusion<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br>ACTUAL SIGNATURE Frank J. Broschek M.D.<br>EXAMINER'S NAME (Type) FRANK J. Broschek M.D.<br>DATE SIGNED 9-28-61<br>22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial<br>22b. DATE THEREOF<br>9/26/61<br>22c. NAME OF CEMETERY OR CREMATORY<br>Monocacy Cemetery<br>22d. LOCATION (City, town, or county) (State)<br>Bealsville Maryland<br>23. FUNERAL DIRECTOR<br>Warner E. Humphrey, Inc.<br>ADDRESS<br>8434 Georgia Avenue<br>Silver Spring, Maryland<br>24b. REC'D BY REGISTRAR<br>24c. REGISTRAR'S SIGNATURE<br>SEP 26 '61 |  |  |  |



## PHYSICIAN CERTIFICATION

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

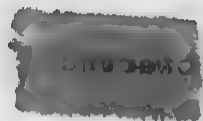
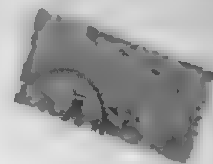
10381

## CERTIFICATE OF DEATH

10376

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b> <u>Montgomery</u> <b>MARYLAND</b><br><b>b. CITY OR TOWN</b> (If out of corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br><b>c. LENGTH OF STAY IN</b> <u>1b</u><br><b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address)<br><u>8803 Melwood Road</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br><b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Montgomery</u><br><b>c. CITY OR TOWN</b> (If out of corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br><b>d. STREET ADDRESS</b><br><u>8803 Melwood Road</u> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Florence</u><br><b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/><br><b>10e. U.S.A. OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u><br><b>13. FATHER'S NAME</b><br><u>William McDowell</u>   |  | <b>8. DATE OF DEATH</b><br><u>Sept. 12 19 61</u><br><b>9. AGE</b> (In years last birthday)<br><u>76</u> yrs.<br><b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>England</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u><br><b>16. SOCIAL SECURITY NO.</b><br><u>364-03-6552</u><br><b>17. INFORMANT</b><br><u>Margery D. Howarth-daughter-same 2d</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Augusta Gwyane</u><br><b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a).</b> <u>Arterial Vascular Disease - Paroxysmal</u><br><b>(b)</b> <u>Cerebral arteriosclerosis</u><br><b>(c)</b> <u>Cerebral arteriosclerosis</u><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/><br><b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.<br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April 20, 1958</u> , to <u>Sept. 12, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 29, 1961</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.<br><b>22a. SIGNATURE</b> <u>Jack Kleh</u> <b>M.D.</b><br><b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Jack Kleh</u><br><b>22d. ADDRESS</b><br><u>915-19th Street, N. W. Wash. D. C.</u><br><b>22e. DATE SIGNED</b><br><u>9/12/61</u><br><b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Bur, Transit</u> <b>23b. DATE THEREOF</b> <u>9/14/61</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Roseland Park Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Oakland County, Michigan</u><br><b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u> <b>25a. REC'D BY REGISTRAR</b> <u>SEP 14 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>   |  |   |  |

within 24 hours after death. The law requires that the death certificate be examined by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10382

## CERTIFICATE OF DEATH

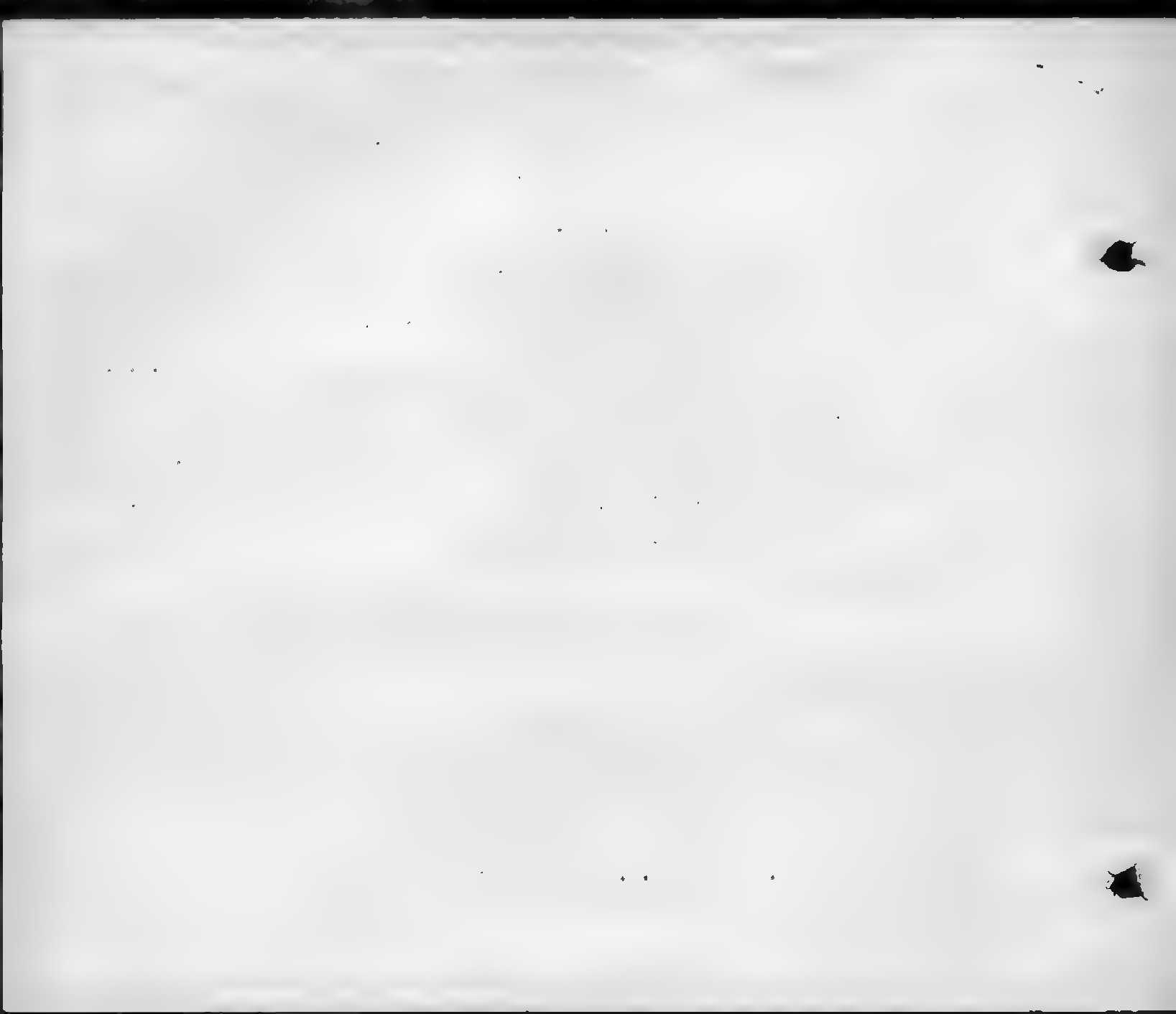
Reg. Dlt No. 10377

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>65 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE<br><b>North Carolina</b><br>b. COUNTY<br><b>Winston-Salem</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Winston-Salem</b><br>d. STREET ADDRESS<br><b>341 Gregory Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Ray</b> Last <b>Huffman</b>   |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>20</b> Year <b>1961</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>November 13, 1930</b> |
| 9. AGE (In years last birthday) yrs. <b>30</b>   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chief Operator</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tobacco</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Glenn Davis Huffman</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ila Nellie Hooser</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unascertainable</b>  |  |
| 17. INFORMANT<br><b>The Medical Record</b>   |                                  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b><br>DUE TO <b>Wegener's Granulomatosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 months</b><br>DUE TO (c) <b>10 months</b>  |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>July 17, 1961</b> to <b>September 20, 1961</b> , that I last saw the deceased alive on <b>September 20, 1961</b> , and that death occurred at <b>11:43A M.</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b><br>DATE SIGNED <b>9/21/61</b> |                                  |  |  |
| ACTUAL SIGNATURE <b>William T. Butler</b>  |                                  | M.D. <b>William T. Butler, M.D.</b>  |  |
| PHYSICIAN'S NAME (Type) <b>WILLIAM T. BUTLER, M.D.</b>   |                                  | ADDRESS <b>Bethesda 14, Maryland</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur-Transit 9/21/61</b>  |                                  | 22b. DATE THEREOF <b>9/21/61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Home Park</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Winston Salem, N. Carolina</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>SEP 27 '61</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur P. Harris</b>  |                                  |  |  |

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

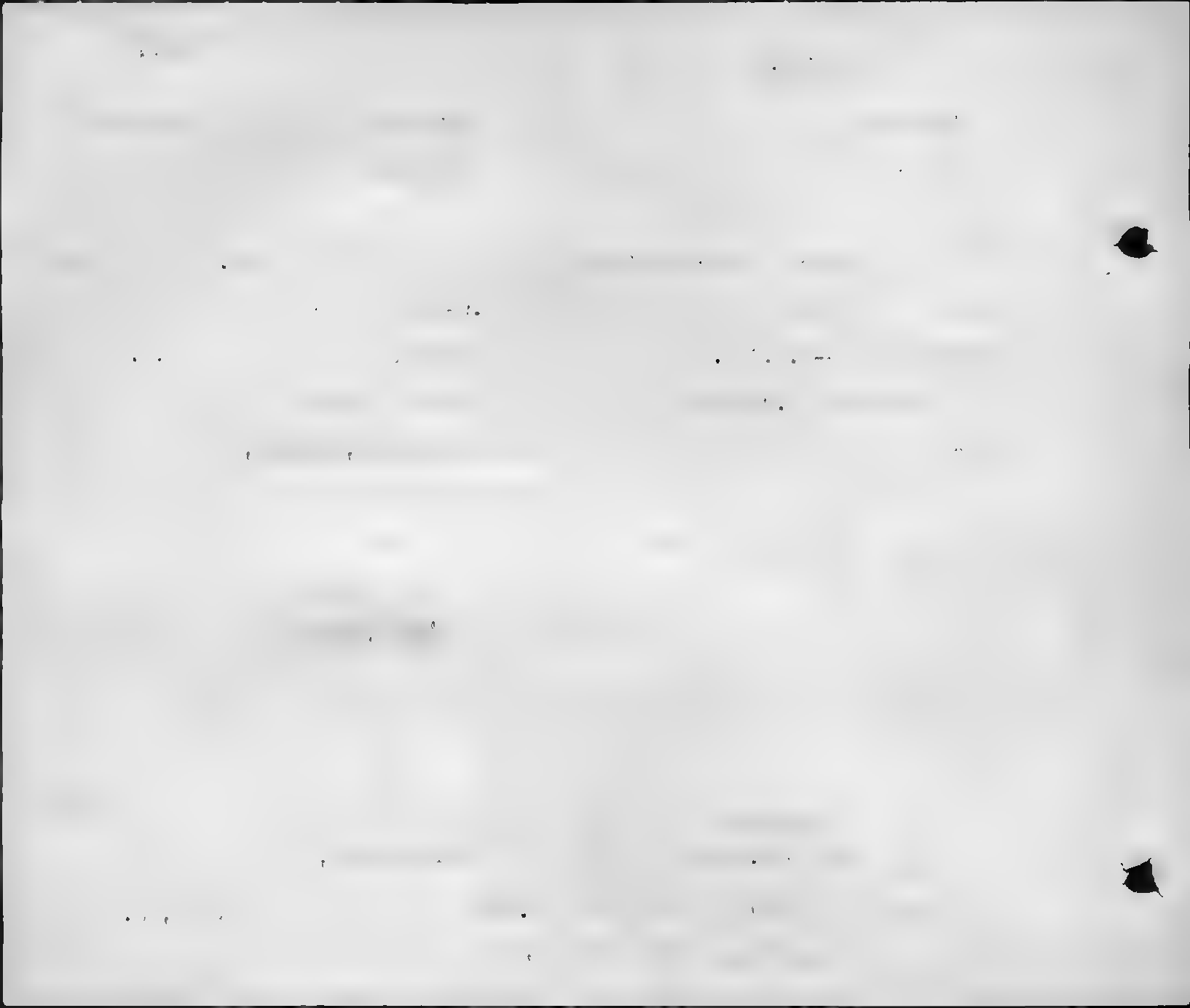
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10383

## CERTIFICATE OF DEATH

10378

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Sellman</b><br>c. LENGTH OF STAY IN 1b <b>25</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sellman</b><br>d. STREET ADDRESS |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <b>Richard</b> Middle <b>Magruder</b> Last <b>Hughes</b><br>5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 9-1914</b><br>9. AGE in years <b>46</b> (last birthday) IF UNDER 1 YEAR: Months Days Hours Min. |  | <b>4. DATE OF DEATH</b><br>Month <b>Sept.</b> Day <b>4</b> Year <b>1961</b><br>a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Clerk--U.S. Gov.</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State or foreign country) <b>Georgia</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  |   |  |
| 13. FATHER'S NAME <b>Benjamin R. Hughes</b><br>14. MOTHER'S MAIDEN NAME <b>Cornelia Follin</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b><br>16. SOCIAL SECURITY NO. <b>Benjamin Hughes, Sellman, Md</b><br>17. INFORMANT Address   |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardiovascular Disease</b><br>(c), stating the underlying cause last. DUE TO  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>6 years</b>   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><b>Bronchial Asthma, Chronic Alcoholism</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>16 Nov 1950</b> to <b>4 Sept 1961</b> , that (I) <del>(the)</del> last saw the deceased alive on <b>4 Sept 1961</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><b>Gordon M. Smith</b>  |  | 22b. DATE SIGNED<br><b>4 Sept 61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Gordon M. Smith</b>  |  | 22d. ADDRESS<br><b>Barnesville, Md</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>9/7/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Mem. Park</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Falls Church, Va.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William B. Hillon</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 11 '61</b><br>25b. REGISTRAR'S SIGNATURE<br><b>William B. Hillon</b>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10379

FOR STATE HEALTH-DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |   |                                      |
|--|---|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u>                                  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. #1-Box 238- Gladhill Rd.</u>  |   | d. STREET ADDRESS <u>IRD #1-Box 238- Gladhill Rd</u>  |                                      |
| 3. NAME OF DECEASED (Type or print) <u>Robert Amel Hunter</u>  |   | 4. DATE OF DEATH <u>9-28-</u> 19 <u>61</u>  |                                      |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-30-1888</u>    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator, Retired</u>   |   | 11. BIRTHPLACE (State or foreign country) <u>Del</u>  |                                      |
| 13. FATHER'S NAME <u>Unknown</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>302-09-5663-</u>   |                                      |
| 17. INFORMANT <u>Robert Hunter Jr. Dickerson, MD</u>   |   | Address   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO <u>hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <u>hypertension</u><br>DUE TO <u>hypertension</u>   |   | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>  |                                      |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 a)  |   |   |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |                                      |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                      |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |   | 22b. DATE THEREOF <u>9/30/61</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>  |   | 22d. LOCATION (City, town, or country) (State) <u>Clarksburg, MD</u>  |                                      |
| 23. FUNERAL DIRECTOR <u>William B. Hilton, Barnesville MD</u>  |   | 24a. REC'D BY REGISTRAR <u>OCT 2 '61</u>  |                                      |
|  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>  |                                      |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21  
FOR STATE  
HEALTH DEPT.

10385

10386

|   |                                 |   |  |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda D.O.A.</u>   |                                 | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>                                   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>  |                                 | e. STREET ADDRESS <u>115-Muncaster Mill Rd</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>William Alford Johnson</u>  |                                 | 4. DATE OF DEATH <u>Sept 1 1961</u>   |  |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>9-13-28</u>                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (in years last birthday) <u>35</u> yrs. |
| 13. FATHER'S NAME <u>Raymond Johnson</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>Rebecca Barnett</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                                 | 16. SOCIAL SECURITY NO. <u>1944-1447</u>  |  |
| 17. INFORMANT <u>Rebecca Barnett</u>  |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                                 |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <u>EXHAUSTION</u>   |                                 |   |  |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>HEART ATTACK OF HORTZ</u>   |                                 |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>CONGESTED HEART</u>   |                                 |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                 |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot with pistol</u>                 |  |
| 20c. TIME OF INJURY Month, Day, Year <u>7:00 p.m. 9-1-61</u>  |                                 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Refugee sat</u>   |                                 | 20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |   |  |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u>   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>   |                                 | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                                 | 22b. DATE THEREOF <u>9-7-61</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>  |                                 | 22d. LOCATION (City, town, or country) <u>Rockville, Md.</u> (State) <u>md</u>  |  |
| 23. FUNERAL DIRECTOR <u>Robert C. Lawrence</u>  |                                 | 24a. REC'D BY REGISTRAR <u>SEP 8 '61</u>  |  |
| ADDRESS <u>Rockville, Md.</u>   |                                 | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>  |  |

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

~~Father~~ Mother 11598

|  |                                |   |   |
|--|--------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery Co.</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br>c. LENGTH OF STAY IN b<br><u>26 hours</u>  |                                | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Rockville</u><br>d. STREET ADDRESS<br><u>322 Lincoln Ave</u> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Infant Girl</u><br>First Middle Last<br><u>Topsy</u>  |                                | 4. DATE OF DEATH<br>Month Day Year<br><u>Sept 29 1961</u>   |   |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>9-28-61</u> AM   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><u>1</u> yrs. <u>1</u> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Montgomery Co. Md.</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>   |   |
| 13. FATHER'S NAME  |                                | 14. MOTHER'S MAIDEN NAME<br><u>Topsy, Barbara</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><u>Taken from record - Mother</u>   |                                | Address   |   |
| 18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><u>776X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause last,<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><u>Incompetent Cervix?</u> |                                |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                |   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |                                | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from.....19....., to.....19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.   |                                |   |   |
| 22a. SIGNATURE<br><u>R. M. Barnett Jr.</u>   |                                | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>R. M. BARNETT, JR., M.D.</u>  |                                | ATTENDING PHYSICIAN'S NAME (Type)<br><u>STAFF</u>   |   |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><u>CREMATION</u>   |                                | 23b. DATE THEREOF<br><u>10/11/61</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>SUBURBAN HOSPITAL</u>   |                                | 23d. LOCATION (City, town or county) (State)<br><u>BETHESDA, MD.</u>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>AMELIA C. CARTER, ADMIN. - SUBURBAN HOSP. BETHESDA, MD.</u>   |                                | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 16 '61</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>   |                                |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



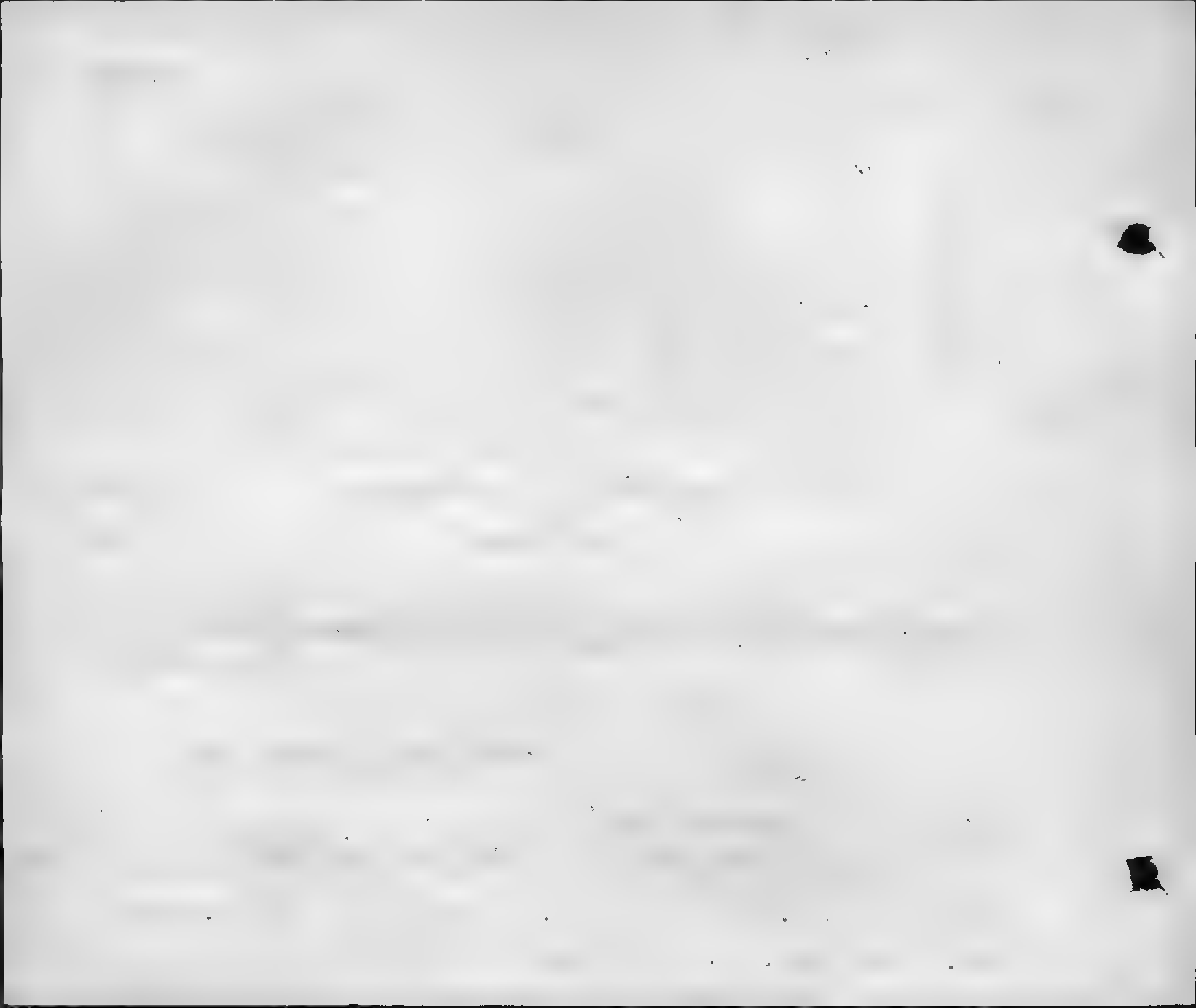


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10387  
10380  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>6 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>75 Wash. San &amp; Hospital</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>9621 Landale Drive</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last <u>Joseph</u> <u>Paul</u> <u>Ireland</u>  |  | 4. DATE OF DEATH<br>Month Day Year <u>9</u> <u>22</u> <u>1961</u>   |  |
| 5. SEX <u>male</u><br>6. COLOR OF RACE <u>white</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <u>2/4/87</u><br>9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min. |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Inspector U.S. Gov't</u><br>11. BIRTHPLACE (County & State or foreign country) <u>D. C.</u><br>12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>  |  |
| 13. FATHER'S NAME <u>Joseph L. Ireland</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Mary Thorn</u><br>Address <u>Harp Road</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWII</u>   |  | 16. SOCIAL SECURITY NO. <u>331X</u>   |  |
| 17. INFORMANT <u>Harp Road</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br><u>Hypertension</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>331X</u><br>DUE TO<br>cause, stating the underlying cause last. (c) <u>several years</u>                                       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus, gastritis superficial mucositis</u>  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>hemorrhage</u>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 22, 1952</u> to <u>Apr. 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr. 22, 1961</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.   |  |   |  |
| 22. SIGNATURE<br><u>John N. Andrews</u> M.D.<br>22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>  |  | 22d. ADDRESS<br><u>9601 Colesville Rd Silver Spring Md</u>  |  |
| 22e. DATE SIGNED<br><u>9-23-61</u>   |  | 22f. SIGNATURE<br><u>Arthur L. Hines</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>9.26.1961</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Lee Funeral Home</u>  |  | 25a. REC'D BY REGISTRAR<br><u>26 61</u>   |  |
| 25b. REGISTRAR'S SIGNATURE   |  | 25c. REGISTRAR'S SIGNATURE  |  |



10388

## CERTIFICATE OF DEATH

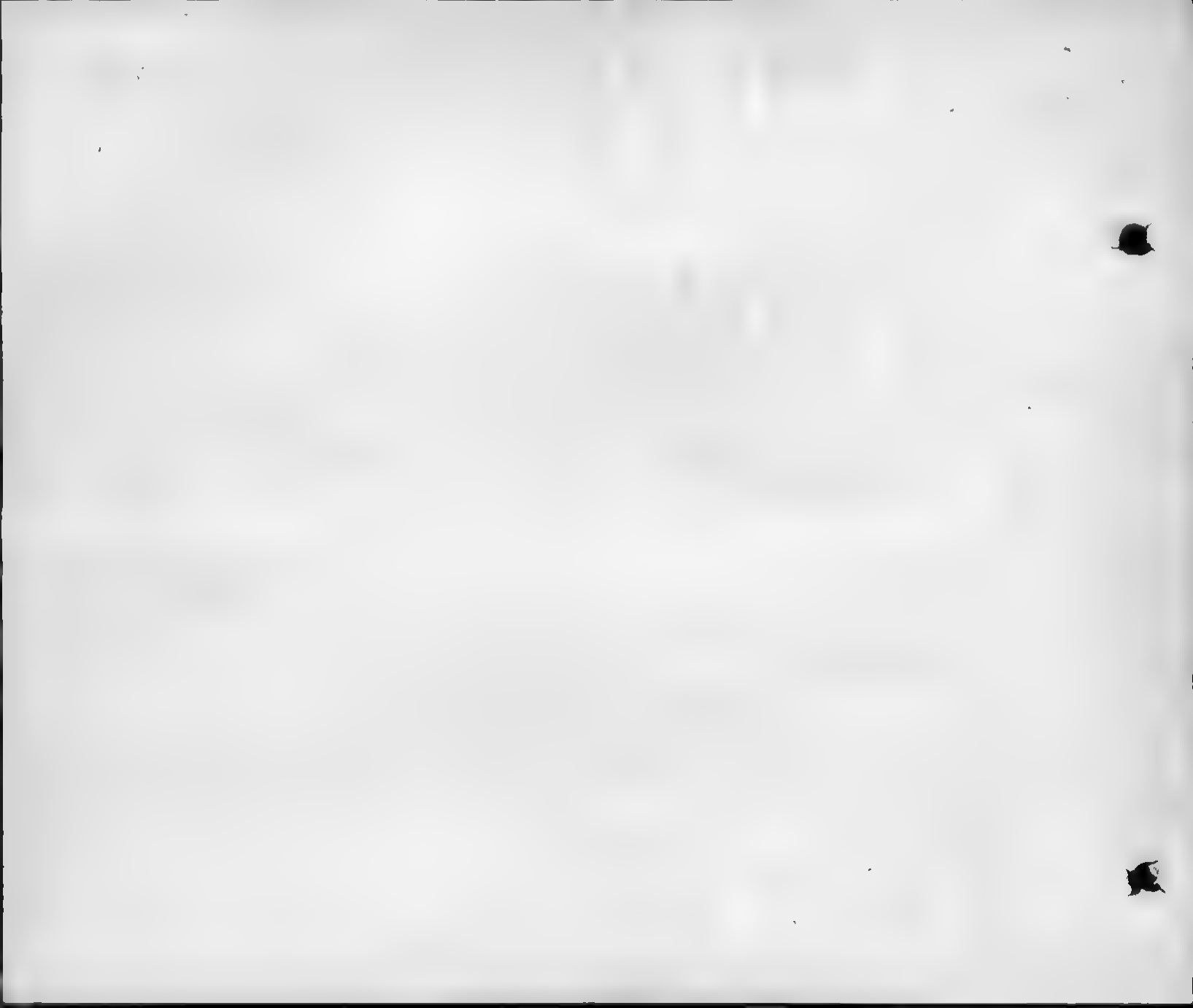
Reg. Dist. 10381

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mont. County</u> <u>Olney</u> <del>MARYLAND</del>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u><br>b. COUNTY <u>Montgomery</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda Md</u> <u>44</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brocke Grove Nursing Home</u> <u>Olney and</u>   |  |  |  | d. STREET ADDRESS <u>5808 Ipswich Rd</u> <u>Md.</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Lucy</u> First <u>Gertrude</u> Middle <u>Ivory</u> Last   |  |  |  | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1961</u>   |  |  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Apr. 28, 1875</u>                                  |  |
| 9. AGE (In years last birthday) <u>86</u> yrs  |  | IF UNDER 1 YEAR Months <u>8</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u> |  | IF UNDER 24 HRS  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book-keeper</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bookkeeping</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>         |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>Benjamin F. Gerry</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Cleora (Unknown)</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT <u>Austin Ivory</u> Address <u>Bethesda Md</u>           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br><u>592X</u> DUE TO <u>Leukemia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic Nephritis</u><br>DUE TO <u>2 yr</u><br>(c) <u>2 yr</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Hiatus Hernia</u>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>61</u> , to <u>9/25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/23</u> , 19 <u>61</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.   |  |  |  | ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u> DATE SIGNED <u>9/25/61</u>  |  |  |  |
| ACTUAL SIGNATURE <u>C. H. Ligon</u> M.D.   |  |  |  | PHYSICIAN'S NAME (Type) <u>Sandy Spring, Maryland</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> <u>9/25/61</u>  |  |  |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>         |  |
| 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>  |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS   |  |  |  | 24a. REC'D BY REGISTRAR <u>SEP 27 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>                     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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VS. A15ME  
5M 7/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10389 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film C297-10/23/61 mh

10382

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>e. STATE <u>md</u> b. COUNTY <u>Montg</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park D.O.A.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>                           |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington State Hosp</u>   |  | d. STREET ADDRESS<br><u>18000 Blair Mill Dr</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Caroline May Jabant</u>  |  | 4. DATE OF DEATH<br><u>Sept 19 1961</u>  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>11-20-1915</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Clerk</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>N.Y.</u>   |  |
| 13. FATHER'S NAME<br><u>Aaron O. Black</u>   |  | 14. MOTHER'S M maiden NAME<br><u>Phoebe Rogers</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT<br><u>Alan R. Jabant</u>   |  | Address <u>Stun 2</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO (b) <u></u><br>DUE TO (c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                       |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m. <u></u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                          |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br><u>Frank J. Broschant</u>  |  | DATE SIGNED<br><u>9-20-61</u>  |  |
| EXAMINER'S NAME (Type)<br><u>FRANK J. Broschant</u>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22b. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cemetery</u>   |  |
| 22d. DATE THEREOF<br><u>9/22/61</u>  |  | 22e. LOCATION (City, town, or country) (State)<br><u>Washington D.C.</u>   |  |
| 23. FUNERAL DIRECTOR<br><u>Raymond A. Ziska</u>  |  | 24. REC'D BY REGISTRAR<br><u>SEP 21 '61</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Charles E. Hines</u>  |  | 24c. ADDRESS<br><u>8434 Georgia Avenue</u>   |  |
| 24d. ADDRESS<br><u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10390

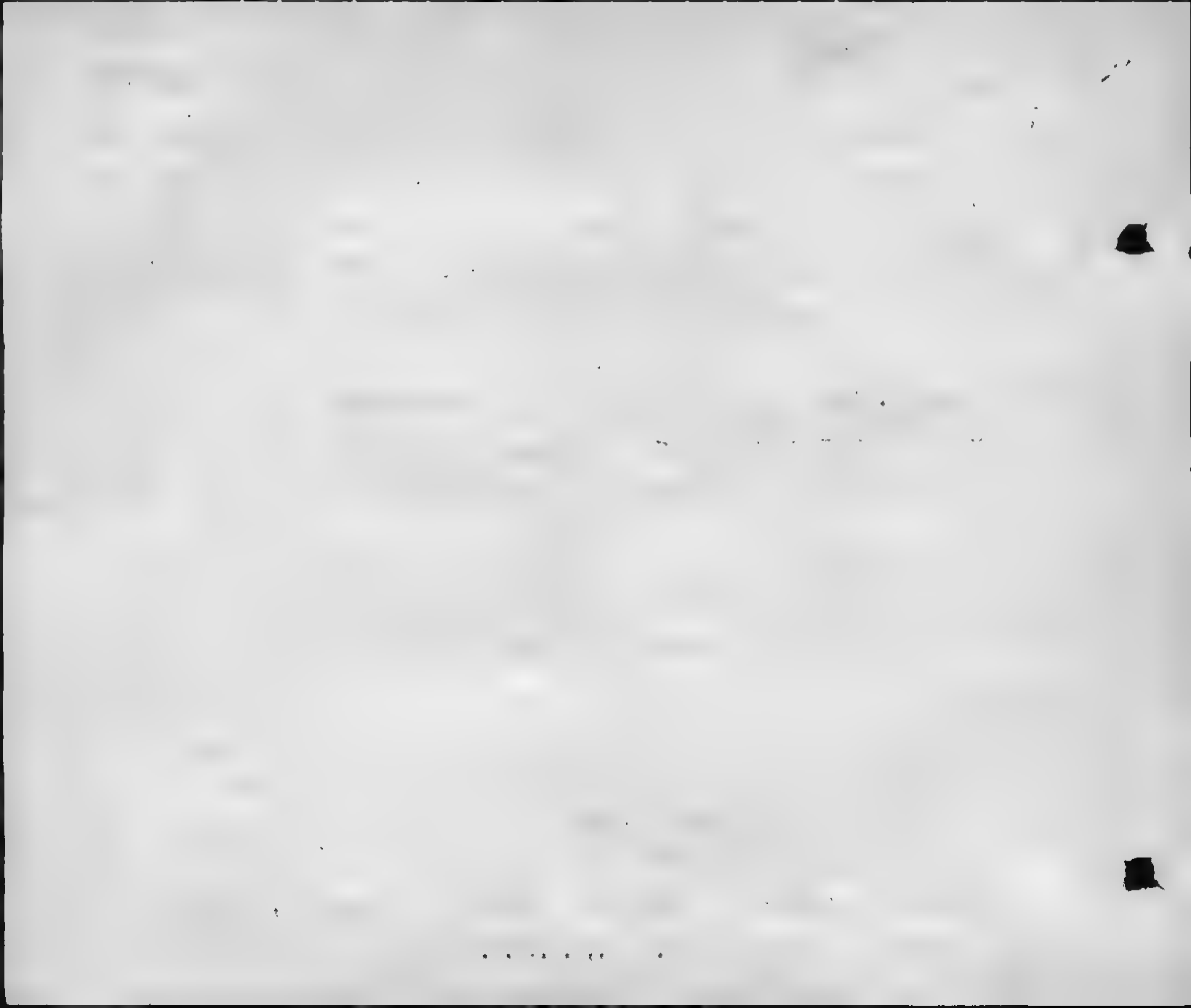
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10383

**FOR STATE HEALTH DEPT.**

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY in 1b _____<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5132 Scarsdale Rd</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>d. STREET ADDRESS <u>5132 Scarsdale Rd</u>  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Otto M. Jank</u><br>First Middle Last  |  |  |  | <b>4. DATE OF DEATH</b><br><u>Sept 2 1961</u><br>Month Day Year  |  |  |  |
| <b>5. SEX</b><br><u>Male</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Col U.S.A</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>retired</u>   |  | <b>9. AGE</b> (In years last birthday) <u>64</u> yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS: Hours _____ Min. _____   |  |  |  |
| <b>11. BIRTHPLACE</b> (State or foreign country) <u>Mass.</u>   |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A</u>  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>ROBERT C. JANK</u>   |  |  |  | <b>14. MOTHER'S M.A.DEN NAME</b><br><u>PAULINE SCHULTZ</u>   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>YES 1917 TO 1949</u>  |  |  |  | <b>16. SOCIAL SECURITY NO</b> _____  |  |  |  |
| <b>17. INFORMANT</b><br><u>Ruth Jank (wif)</u> Address <u>Blum</u>  |  |  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) _____<br>PART I OTHER SIGNIFICANT COND.T.ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.T.ON GIVEN IN PART 1 a) _____ |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> _____<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I. of item 18.) _____  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month Day, Year<br>Hour a.m. _____ p.m. _____ 19____  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____<br><b>20f. (City or town, (County) (State) _____</b>   |  |  |  |
| <b>21 I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from.</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D.<br><b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Broschert</u>   |  |  |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>9-2-61</u>  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>CREMATION</u>   |  | <b>22b. DATE THEREOF</b> <u>9/5/1961</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL CREMATORY</u>  |  |  |  |
| <b>22d. LOCATION</b> (City, town, or country) <u>SUITLAND, MARYLAND</u>   |  | <b>23. FUNERAL DIRECTOR</b><br><u>Joseph Sawler Inc</u> ADDRESS <u>1756 PA. AVE., N.W., D.C. 6</u>               |  |  |  |  |  |

TO THE CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

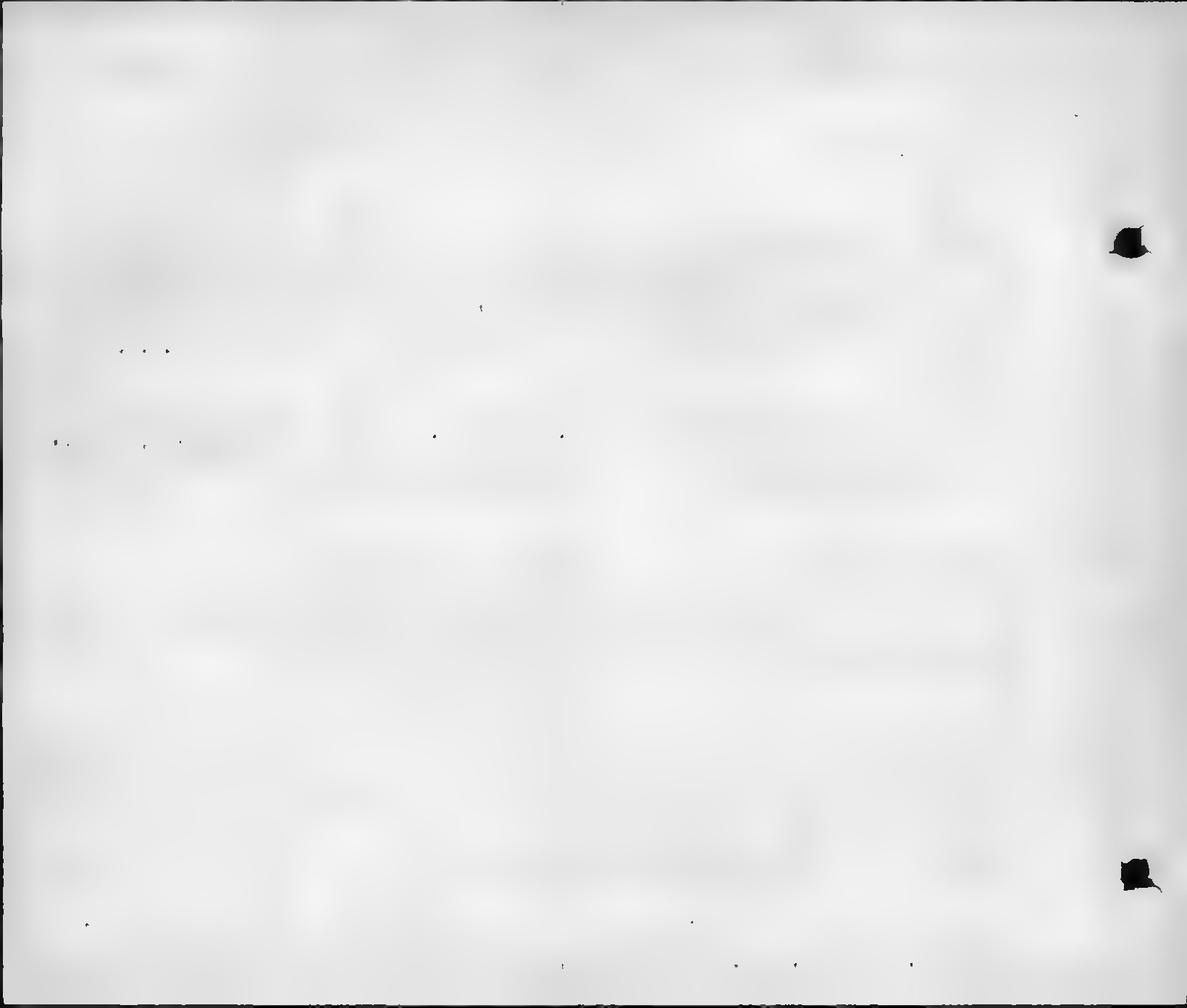
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10391

## CERTIFICATE OF DEATH

Reg. Dist. No. 10384

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b>         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>322 Highview Avenue</b>   |  | d. STREET ADDRESS<br><b>328 Highview Avenue</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Maxine Vera Marie Jefferson</b>   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>11</b> Year <b>1961</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 12, 1898</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Indiana</b>                       |
| 13. FATHER'S NAME<br><b>Eugene Golay</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Rader</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT<br><b>Mr. Charles E. Jefferson</b>                                  |
|   |  | Address<br><b>328 Highview Avenue<br/>Silver Spring, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Ulcerational Colitis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic heart disease with left bundle branch block</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour <b>a. 11</b> Month, <b>19</b> Day, <b>19</b> Year<br>p. m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>October, 1960</b> to <b>Sept 11, 1961</b> , that I last saw the deceased alive on <b>Sept 8, 1961</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.  |  |  |   |
| ACTUAL SIGNATURE<br><b>Sydney Leventhal</b>   |  | ADDRESS (Street, city or town, state)<br><b>9210 Colesville Rd., Silver Spring, Md.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Sydney Leventhal, M.D.</b>  |  | DATE SIGNED<br><b>Sept 11, 1961</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>9/13/61</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington County Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner &amp; Pumphrey, Inc.</b>  |  | 24. REC'D BY REGISTRAR<br><b>SEP 13 '61</b>  |   |
| ADDRESS<br><b>8434 Georgia Avenue<br/>Silver Spring, Maryland</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>C. Earl S. Kraus</b>  |   |



1  
FOR STATE  
HEALTH DEPT.

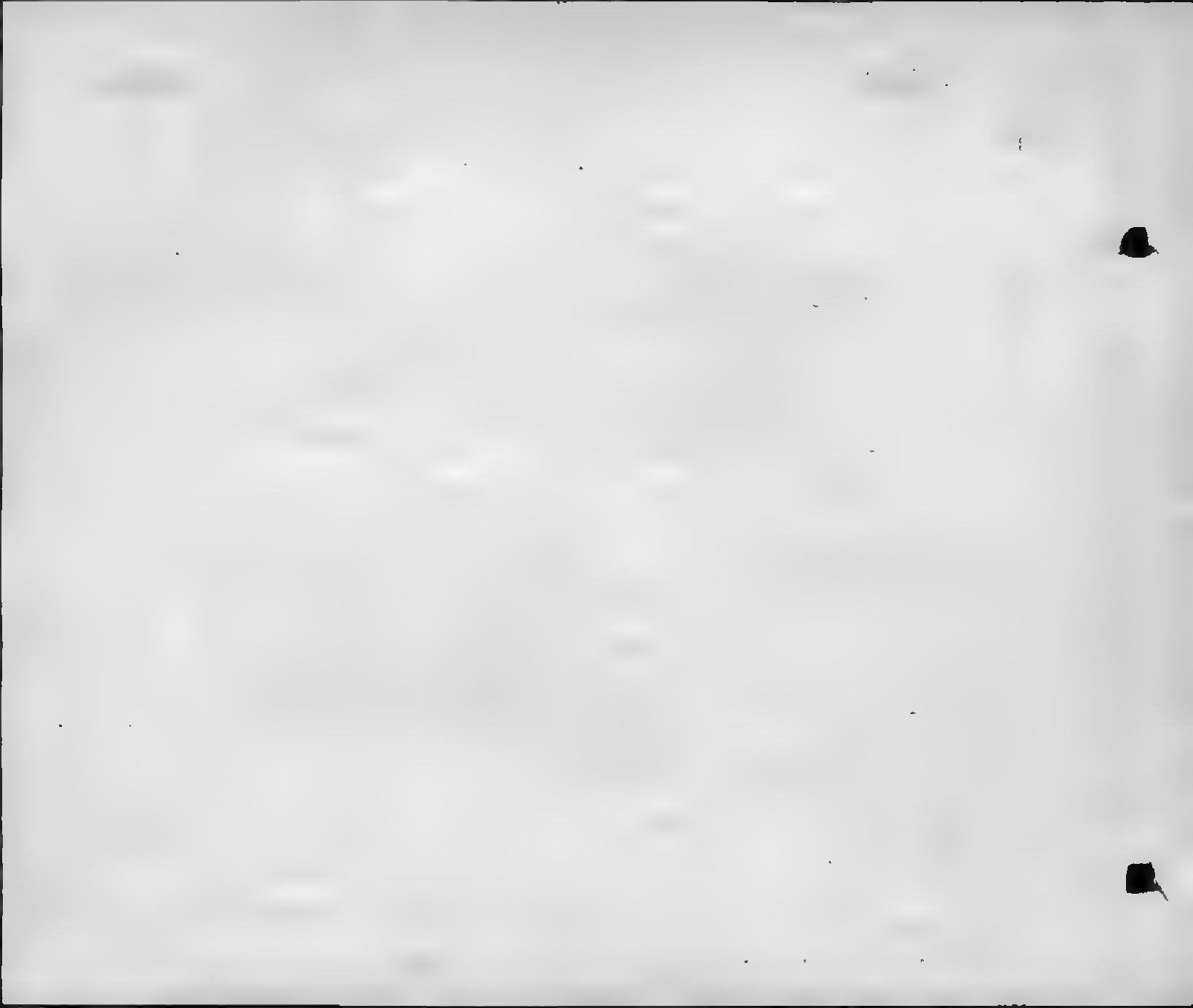
TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. delay is necessary, please 3 execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

10392  
MARYLAND STATE HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |                                      |  |  |  |
|--|--|---|--|--|--|---|--|---|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|--------------------------------------|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Olney   |  | c. LENGTH OF STAY IN lb<br>5 1/2 hrs.                      |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission)<br>a. STATE<br>Maryland   |  | b. COUNTY<br>Montgomery   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Silver Spring  |  | d. STREET ADDRESS<br>914 Snider Lane   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |   |  |   |  |                                      |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Montgomery General Hospital  |  | 3. NAME OF DECEASED<br>(Type or print)<br>Roberta Elizabeth Jenkins   |  | First Middle Last  |  | 4. DATE OF DEATH<br>Month Day Year<br>9 29 1961   |  | 5. AGE (In years last birthday)<br>53 yrs.  |  | 6. DATE OF BIRTH<br>9/18/1908  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. COLOR OR RACE<br>female white  |  |  |  |   |  |   |  |   |  |                                      |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Virginia      |  | 12. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 13. FATHER'S NAME<br>Wilford Hairfield  |  | 14. MOTHER'S MAIDEN NAME<br>Clearena Wolfrey   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.<br>None   |  |  |  |   |  |   |  |   |  |                                      |  |  |  |
| 17. INFORMANT<br>Hospital Records  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subdural + cerebral hemorrhage (left)</u><br>312X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br>5 1/2 hrs<br>5 1/2 hrs |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Fracture - 7-8-9-10-11-12 ribs (left)</u> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/><br><u>Pedestrian - Struck by auto</u> |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II of item 18.)<br><u>highway</u>  |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>4:20 p.m. 9/29/61                                      |  | 20d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>cloverly</u> |  | 20f. (City or town)<br>Montg. Md.   |  | 20g. (County)<br>Montg. Md.                     |  | 20h. (State)<br>Md.                  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:<br>Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>        |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DATE SIGNED<br>9/30/61  |  | ACTUAL SIGNATURE<br><u>Frank J. Broschart</u>  |  | EXAMINER'S NAME (Type)<br>Frank J. Broschart   |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 22b. DATE THEREOF<br>10/3/61   |  | 22c. NAME OF CEMETERY OR CREMATORY<br>George Washington Cemetery                          |  | 22d. LOCATION (City, town, or country) (State)<br>Prince George's County Maryland |  | 23. FUNERAL DIRECTOR<br><u>Raymond A. Ziska</u> |  | 24a. REC'D BY REGISTRAR<br>OCT 3 '61 |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Evans</u> |  |

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

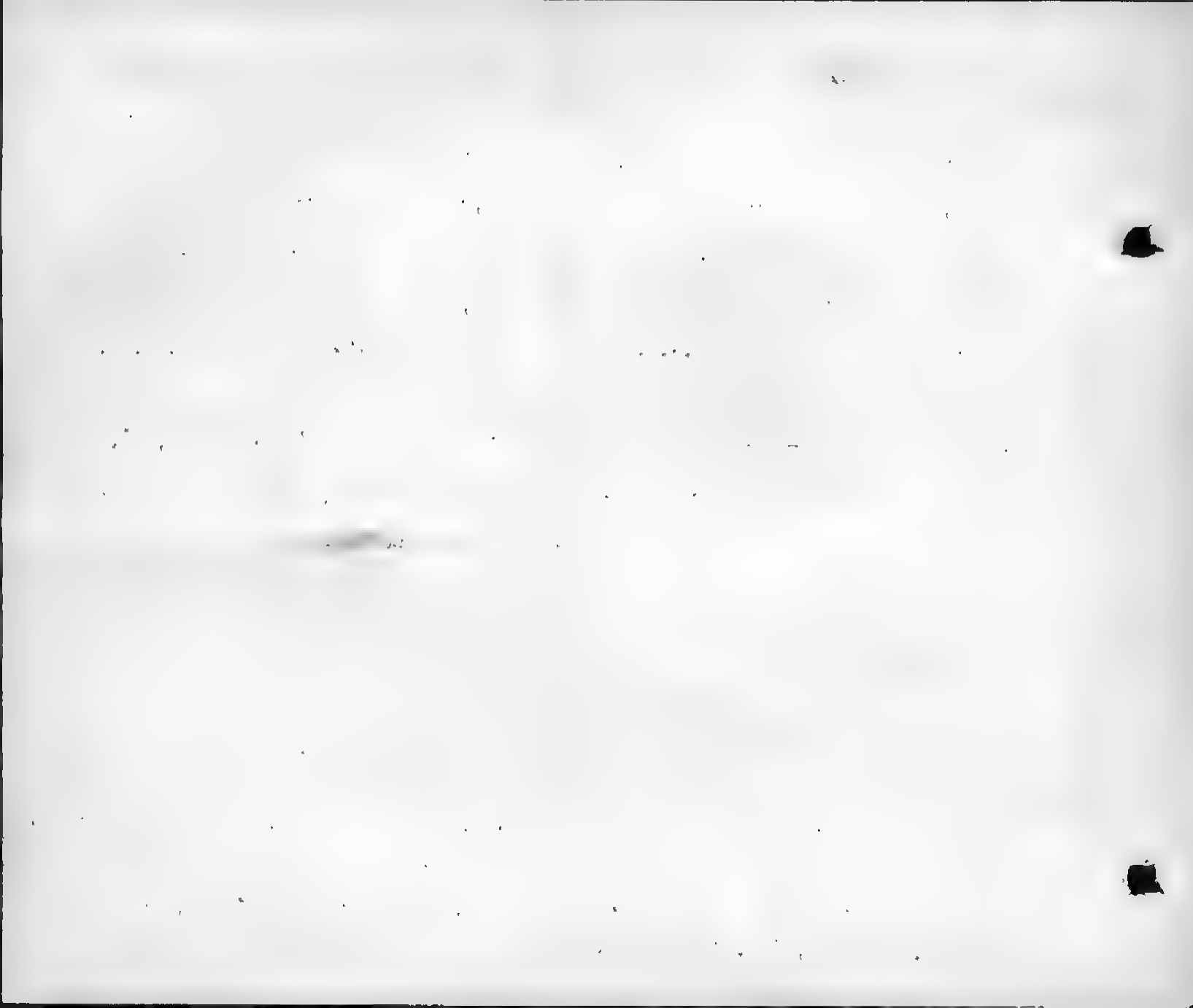
10393

Res. Dist. No. 10387

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>o COUNTY <b>MONTGOMERY</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>o STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>10,009 MARKHAM STREET</b>  |  | d. STREET ADDRESS<br><b>10,009 MARKHAM STREET</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>MARY VOLKMAN KEHOE</b>  |  | 4. DATE OF DEATH<br>Month <b>SEPTEMBER</b> Day <b>26</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 25, 1890</b>  |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min <b>71</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Auditor</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>G.A.O.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington D.C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Charles Henry Volkman</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Sheaffer</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b>   |  | 16. SOCIAL SECURITY NO<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Miss Mary Dexter Kehoe</b>  |  | Address<br><b>10,009 Markham St. Silver Spring, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br>331X DUE TO <b>Cerebral arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>June 1963</b> to <b>Sept 26, 1961</b> , that I last saw the deceased alive on <b>June 1961</b> , and that death occurred at <b>11:35 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>10111 Colquhoun Rd. Silver Spring, Md.</b>   |  |   |  |
| ACTUAL SIGNATURE<br><b>Arthur S. Kneass</b>   |  | M.D. <b>10111 Colquhoun Rd. Silver Spring, Md.</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Arthur S. Kneass</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>9/29/61</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Arlington County, Virginia</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner L. Humphrey, Inc.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 29 '61</b>  |  |
| ADDRESS<br><b>8434 Georgia Avenue Silver Spring, Maryland</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneass</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda<br>c. LENGTH OF STAY IN 1b<br>5 Days<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>District Of Columbia<br>b. COUNTY<br>Washington<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>3013 South Dakota Avenue N.E.<br>d. STREET ADDRESS<br>3013 South Dakota Avenue N.E. |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Kay Melda Kennedy<br>4. DATE OF DEATH<br>September 15, 1961  |  | 5. SEX<br>Female<br>6. COLOR OR RACE<br>Negro<br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH<br>July 22, 1937  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Editorial Clerk<br>10b. KIND OF BUSINESS OR INDUSTRY<br>Government<br>11. BIRTHPLACE (County & State, or foreign country)<br>West Virginia  |  | 9. AGE (In years, last birthday)<br>24 yrs.<br>12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>Bruce Kennedy<br>14. MOTHER'S MAIDEN NAME<br>Cliffie Wallace  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)<br>No<br>16. SOCIAL SECURITY NO.<br>Unascertainable   |  |
| 18. CAUSE OF DEATH (Enter only one cause part one for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HEART FAILURE<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,<br>(b) OPEN HEART SURGERY<br>DUE TO<br>(c) CONGENITAL VENTRICULAR SEPTAL DEFECT<br>PULMONARY HYPERTENSION<br>24 YRS<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POST-OPERATIVE COMPLETE HEART BLOCK; CARDIAC ARREST |  | INTERVAL BETWEEN ONSET AND DEATH<br>1.5 DA.<br>2 DA.<br>24 YRS  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>19<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State)   |  | 21. I certify that (I) (this hospital) attended the deceased from September 10, 1961 to September 15, 1961, that (I) (we) last saw the deceased alive on September 15, 1961, and that death occurred at 4:18 PM from the causes and on the date stated above.   |  |
| 22a. SIGNATURE<br>Richard P. Anderson<br>22c. PHYSICIAN'S NAME (Type)<br>Richard P. Anderson   |  | 22b. DATE SIGNED<br>9-16-61<br>22d. ADDRESS<br>National Institutes Of Health<br>The Clinical Center, Bethesda 14, Md.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial<br>23b. DATE THEREOF<br>9-19-61<br>23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial<br>23d. LOCATION (City, town or county)<br>Md.   |  | 24. FUNERAL DIRECTOR'S SIGNATURE<br>Frazier's Funeral Home<br>25a. REC'D BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br>Arthur S. Hines  |  |









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10396

10390

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u><br>c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chas. San E Hosp</u>           |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; if not, give county and city or town; if outside corporate limits, write RURAL and give nearest town)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>Silver Spring</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1021 Briggs Chaney Rd.</u><br>d. STREET ADDRESS <u>14</u> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Alice Estelle Konigsmacher</u>  |   | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>29</u> Year <u>1961</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>January 8 1877</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs.  |   | 10. IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u>   |   |
| 11. IF UNDER 24 HRS. Hours <u>14</u> Min <u>14</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>American</u>  |   |
| 13. FATHER'S NAME<br><u>Barth</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>7-7-1961</u>  |   |
| 17. INFORMANT<br><u>pit Hays Record</u>   |   | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u><br>DUE TO<br>(c) <u>Generalized Arteriosclerosis</u>  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks</u><br><u>year</u>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town, County) (State)       |
| 21. I certify that (I) (the <u>hospital</u> ) attended the deceased from <u>7-7-1961</u> to <u>9-29-1961</u> , that <u>we</u> last saw the deceased alive on <u>9-29-1961</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE<br><u>ABRAHAM W. DANISH</u>  |   | 22b. DATE SIGNED<br><u>9-30-61</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ABRAHAM W. DANISH</u>  |   | 22d. ADDRESS<br><u>Wash. San. Hosp</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Sept 30, 1961</u>   |   | 23b. DATE THEREOF<br><u>G. WASH. UNIV. MEDICAL SCHOOL</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>1335 14 ST. N.W. WASH. D.C.</u>  |   | 23d. LOCATION (City, town or county) (State)   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>G. Arthur Wallers</u>  |   | 24. ADDRESS<br><u>254 Carroll St. N.W. D.C.</u>  |   |
| 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 2 '61</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Evans</u>   |   |



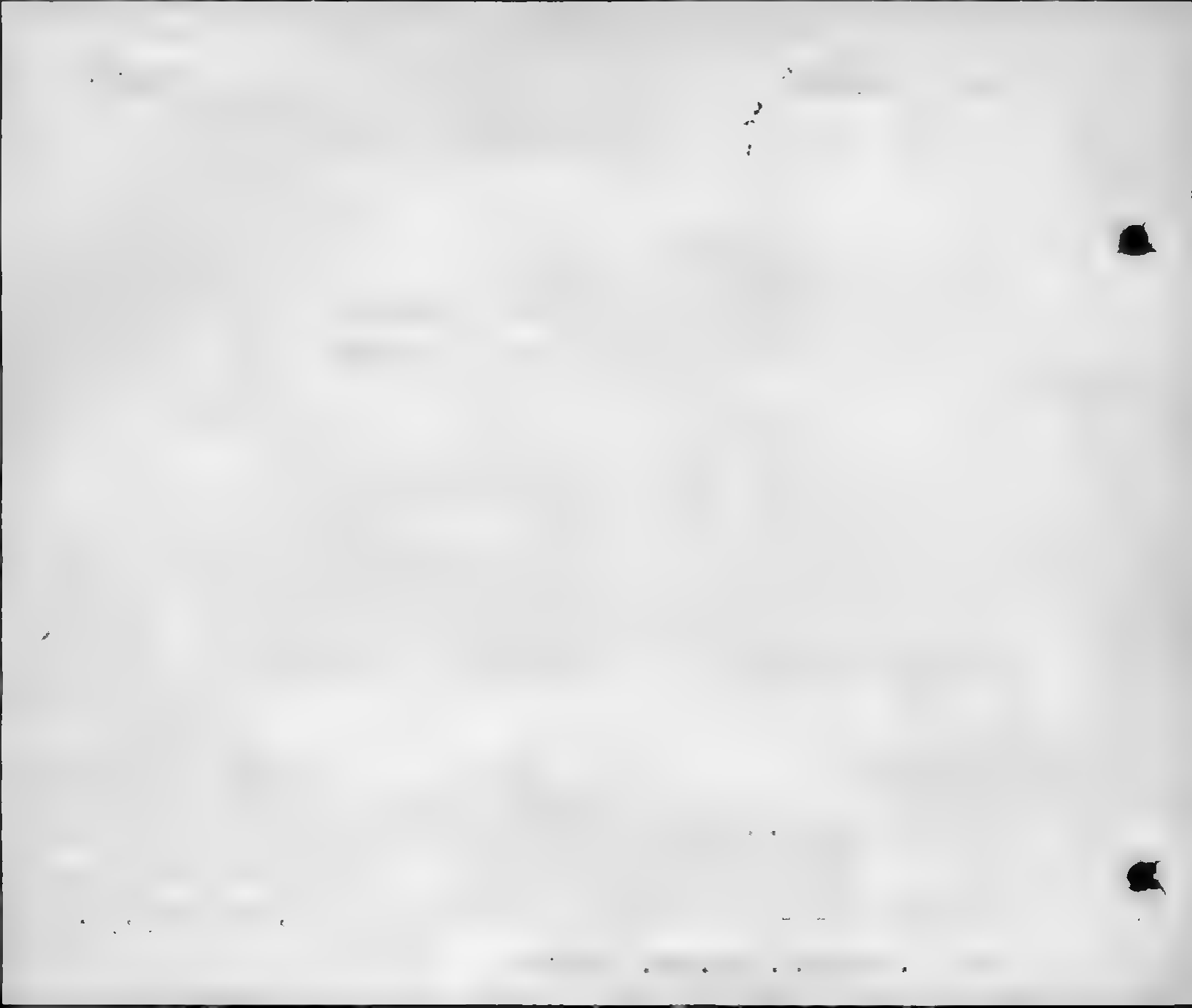
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u> |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>STATE <u>D.C.</u> b. COUNTY <u>D.C.</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>N.W. Washington, D.C.</u><br>d. STREET ADDRESS <u>1914 Conn. Avenue.</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Baby</u><br>4. DATE OF DEATH<br>Month <u>9</u> Day <u>28</u> Year <u>1961</u>   |  | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 27, 1961</u> 9. AGE (In years last birthday) <u>9</u> yrs. IF UNDER 1 YEAR Months <u>14</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u>14</u> Min. <u>3</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>America</u>  |  | 13. FATHER'S NAME <u>David Rex Kriedler</u> 14. MOTHER'S MAIDEN NAME <u>Betty Vaughn Johnson</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Betty Vaughn Johnson</u> Address <u></u>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Prematurity (5 mos)</u><br>Conditions, if any, which gave rise to immediate cause (b) <u></u><br>(c), stating the underlying cause last, <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u></u> |  |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) <u></u> (County) <u></u> (State) <u></u>                              |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from... 19... to... 19..., that (I) (we) last saw the deceased alive on... 19..., and that death occurred at... M, from the causes and on the date stated above.  |  | 22a. SIGNATURE <u>Herbert Diamond, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>H. Diamond M.D.</u> 22d. ADDRESS <u>911- Silver Spring Ave</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>9-28-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital</u> 23d. LOCATION (City, town or county) <u>Takoma Park, Md.</u>  |  | 25a. REC'D BY REGISTRAR <u>OCT 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Wash. San. &amp; Hospital</u>   |  |  |  |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

**10398**

**10392**

|  |                                  |  |   |   |  |   |   |
|--|----------------------------------|--|---|---|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |  |   | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY <span style="float:right">✓</span> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b>   |                                  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington Sanitarium</b>   |                                  |  |   | d. STREET ADDRESS<br><b>5714 Colorado Ave. N.W.</b>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FRANCOES</b> Middle <b>P.</b> Last <b>KURTZ</b>  |                                  |  |   | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>25</b> Year <b>1961</b>   |  |   |   |
| 5 SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>8-21-1898</b>           | 9. AGE (In years last birthday) <b>63</b> yrs   | IF UNDER 1 YEAR<br>Months Days Hours Min.                  | IF UNDER 24 HRS   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Russia</b> ✓ |
| 13 FATHER'S NAME<br><b>Louis Passis (Deceased)</b>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Kuptsow (Deceased)</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>-</b>  |   | 17. <del>IDENTIFICATION</del> Address<br><b>Edith Bernstein 609 Elmira Street S.E.</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Monition and cachexia</b><br><b>2011</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Lymphosarcoma</b><br>DUE TO (c) <b>Cause of cancer</b> |                                  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 months</b><br><b>2-3 yrs</b>                           |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/24/1961</b> to <b>9/25/61</b> that (I) (we) last saw the deceased alive on <b>9/25/1961</b> and that death occurred at <b>10 AM</b> , from the causes and on the date stated above  |                                  |  |   |   |  |   |   |
| 22a. SIGNATURE<br><b>Chas. H. WOLOHON</b>  |                                  |  |   | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                      |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Chas. H. WOLOHON</b>  |                                  |  |   | 22d. ADDRESS<br><b>9601 Carroll Ave T.P. Md</b>   |  |   |   |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/27/1961</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>D.C. Lodge Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b>                          |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Goldberg Funeral Home 4217-0200</b>   |                                  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 27 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>O. J. H. H. H.</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10399

10393

(M)

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Montgomery<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)<br>c. LENGTH OF STAY IN 1b<br>294 days<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U. S. Naval Hospital |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Virginia<br>b. COUNTY<br>Concord<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Route 1<br>d. STREET ADDRESS<br>83 X-3 |  | <b>4. DATE OF DEATH</b><br>Month<br>September<br>Day<br>26<br>Year<br>19 61   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>Roger Lachapelle  |  | <b>5. SEX</b><br>Male  |  | <b>6. COLOR OR RACE</b><br>Caucasian  |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br>9-12-99   |  | <b>9. AGE</b> (in years, last birthday)<br>62 yrs.                            |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Armed Forces   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>U.S. Navy  |  | <b>11. BIRTH-PLACE</b> (County & State, or foreign country)<br>Wisconsin      |  |
| <b>13. FATHER'S NAME</b><br>John Lachapelle  |  | <b>14. MOTHER'S MAIDEN NAME</b><br>Unknown   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>USA                                    |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes WW II   |  | <b>16. SOCIAL SECURITY NO.</b>   |  | <b>17. INFORMANT</b><br>(W) Lena Perl Lachapelle, Same as #2 above            |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)<br>1. Pneumonia<br>DUE TO (b)<br>Carcinoma of Prostate with<br>DUE TO (c)<br>multiple metastases  |  | <b>19. WAS A TUPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | <b>INTERVAL BETWEEN ONSET OF DEATH</b><br>6 wks<br>2 yrs                      |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>  |  |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour e.m. p.m. 19   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |  |
| <b>20f. (City or town)</b>   |  | <b>(County)</b>  |  | <b>(State)</b>  |  |
| <b>21. I certify that</b> (this hospital) attended the deceased from December 6, 1960, to Sept. 26, 1961, that (I) (we) last saw the deceased alive on Sept. 26, 1961, and that death occurred at 11:40 AM from the causes and on the date stated above.   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br>H. S. Irons   |  | <b>22b. DATE SIGNED</b><br>Sept 26, 1961   |  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br>H. S. IRONS, LT MC USN                 |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>Burial   |  | <b>23b. DATE THEREOF</b><br>29 Sept 1961   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>Cedar Bluff Cemetery             |  |
| <b>23d. LOCATION</b> (City, town or county)<br>Annapolis   |  | <b>(State)</b><br>Md.  |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE SEP 29 '61                             |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br>John M. Taylor and Sons Funeral Home, Annapolis, Md.  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br>Arthur S. Kraus   |  |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10400

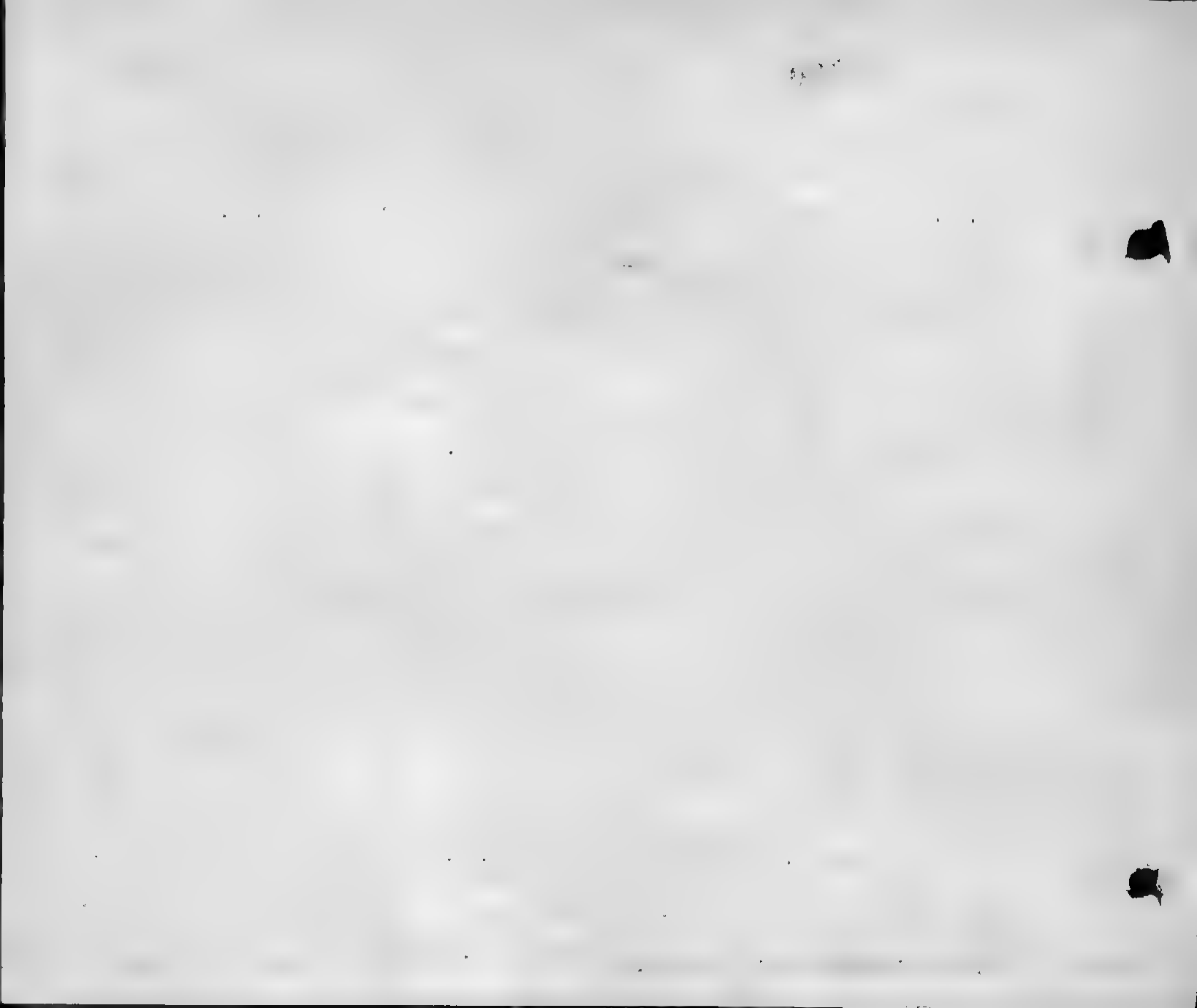
10394

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN 1b <u>13 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>                |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>District of Columbia</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u><br>d. STREET ADDRESS <u>6 Starboard Green, S. W.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Kathleen Ann LEDDY</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>September</u> Day <u>1</u> Year <u>19 61</u>   |  |
| <b>5. SEX</b> <u>Female</u><br><b>6. COLOR OR RACE</b> <u>Caucasian</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>June 1, 1957</u><br><b>9. AGE</b> (In years) <u>4</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u> |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Child</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |  |
| <b>13. FATHER'S NAME</b> <u>Henry Edward Leddy</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine Thelma Sejsersen</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>Henry E. Leddy</u><br><b>17. INFORMANT</b> <u>Same as #2 above</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Internal hemorrhage</u><br>DUE TO (b) <u>Leukemia, acute</u><br>DUE TO (c) <u>204.3</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u><br><u>1 year</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that</b> <u>10</u> (this hospital) attended the deceased from <u>August 19, 1961</u> to <u>September 1, 1961</u> that <u>11</u> (we) last saw the deceased alive on <u>September 1, 1961</u> , and that death occurred at <u>9:02 AM</u> from the causes and on the date stated above.                                  |  |  |  |
| <b>22a. SIGNATURE</b> <u>Robert V. Rack</u> M.D.   |  | <b>22b. DATE SIGNED</b> <u>September 1, 1961</u>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>ROBERT V. RACK, LT MC USN</u>   |  | <b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Shipment</u>  |  | <b>23b. DATE THEREOF</b> <u>9-5-61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Johns Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State) <u>Woodhaven, Queens, New York</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert M. Pumphrey</u>  |  | <b>25a. REC'D BY REGISTRAR</b> <u>SEP 5 '61</u>  |  |
| <b>24. ADDRESS</b> <u>Funeral Home, Bethesda, Md.</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>   |  |

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10401

10395

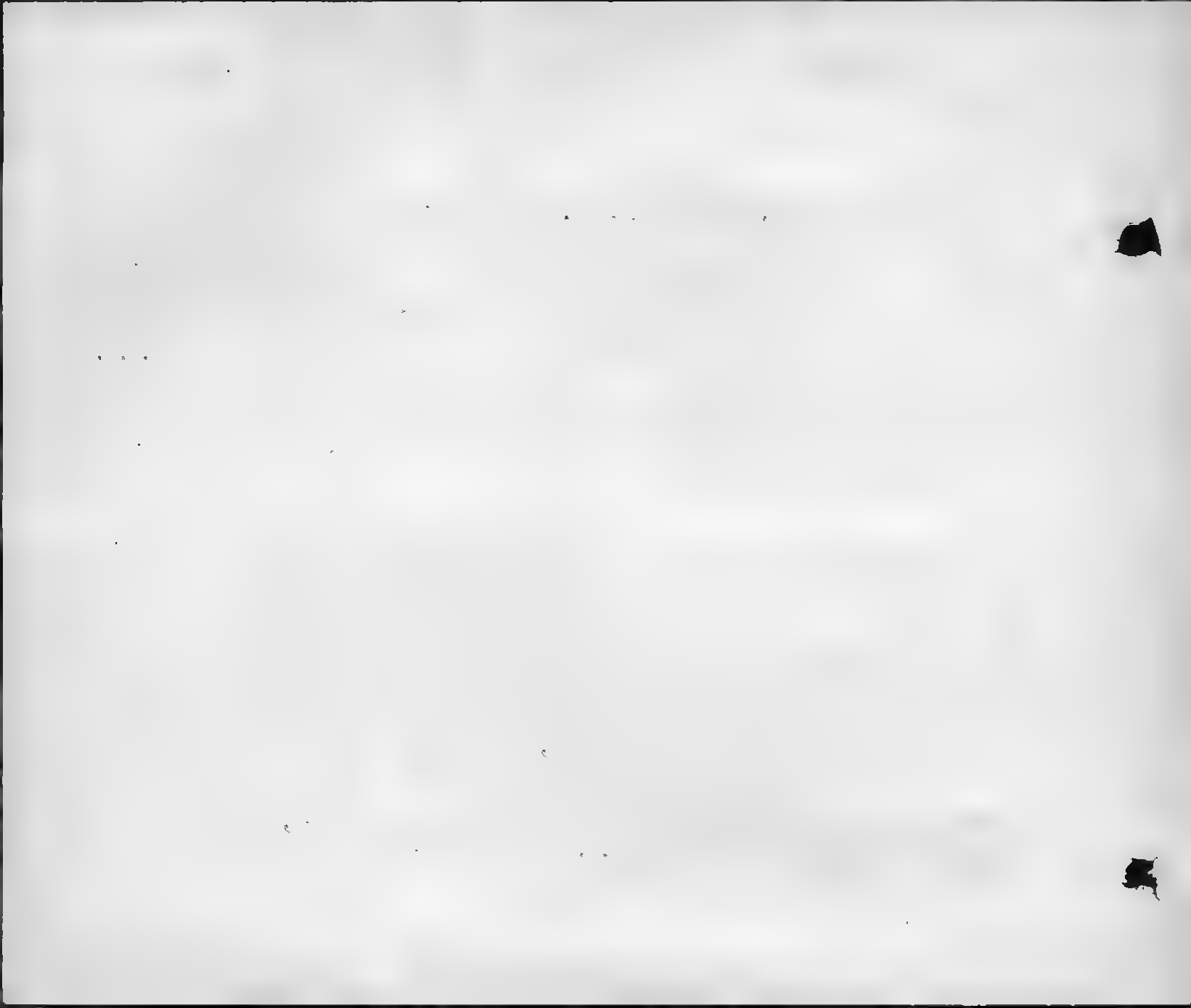
|  |  |  |   |  |  |  |   |
|--|--|--|---|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  |  |   | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE<br><b>Kansas</b><br>b. COUNTY                            |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>25 days</b> |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wichita</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  |  |   | d. STREET ADDRESS<br><b>1717 Saint Francis Street</b>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Anna</b>  |  | Middle<br><b>Mae</b>   |   | Last<br><b>Lee</b>   |  | 4. DATE OF DEATH<br>Month<br><b>September</b> Day<br><b>23,</b> Year<br><b>1961</b>                |   |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>September 13, 1941</b>  |   |
| 9. AGE (In years lost birthday) yrs<br><b>20</b>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>                                       |   |
| 13. FATHER'S NAME<br><b>Homer Landrath</b>   |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary White</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]<br><b>No</b>   |  | 16. SOCIAL SECURITY NO<br><b>None</b>  |   | 17. INFORMANT<br><b>The Medical Record</b> Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Embolus &amp; cardiac arrest</b><br><b>410X</b> DUE TO <b>status</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Postoperative Mitral Insufficiency 2° SOB</b><br>DUE TO (c) <b>Rheumatic heart disease, Aortic</b> |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b><br><b>48 hrs</b><br><b>2</b>                    |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>August 29, 1961</b> to <b>September 23, 1961</b> that I last saw the deceased alive on <b>September 23, 1961</b> and that death occurred at <b>7:10P</b> M, from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b><br>DATE SIGNED <b>9-24-61</b>          |  |  |   |  |  |  |   |
| ACTUAL SIGNATURE <b>Richard P. Anderson</b>  |  | M.D. <b>Richard P. Anderson M.D.</b>   |   |  |  |  |   |
| PHYSICIAN'S NAME (Type)  |  |  |   |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>SHIP RR</b>  |  | 22b. DATE THEREOF<br><b>9-25-61</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>W.W. Chambers Co 400 Chapin St NW</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Wichita Kansas</b>                             |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W.W. Chambers Co</b>  |  | ADDRESS <b>400 Chapin St NW</b>  |   | 24a. REC'D BY REGISTRAR<br><b>DATE 9-26-61</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Christina S. Kneale</b>   |   |

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 10402 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10396

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>1028 Quebec Terrace, Apt. #2</u>   |                               | d. STREET ADDRESS<br><u>1028 Quebec Terrace #2</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Leonard</u> First Middle Last  |                               | 4. DATE OF DEATH <u>Sept. 13</u> Month Day Year <u>1961</u>  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 21, 1901</u>                  |
| 9. AGE (In years last birthday) <u>60</u> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Michigan</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Emanuel Lehto</u>   |                               | 14. MOTHER'S MAIDEN NAME<br><u>Ida ?</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>470-12-2076</u>   |   |
| 17. INFORMANT <u>Aili M. Lehto</u>  |                               | Address <u>1028 Quebec Terrace, Sil. Spr., Md</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic ulcerative colitis</u><br><u>211X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diffuse polyposis of colon</u><br>DUE TO (c) <u>unknown</u>                                 |                               |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 1/2 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>  |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>Sept 13, 1961</u> , that I last saw the deceased alive on <u>Sept 9,</u> 19 <u>61</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>9310 Colesville Rd. Silver Spring, Md.</u> DATE SIGNED <u>Sept 13, 1961</u> |                               |  |   |
| ACTUAL SIGNATURE <u>Sydney Leventhal</u> M.D.   |                               | PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 22b. DATE THEREOF<br><u>9-18-61</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>BAPTIST CEMETERY</u>   |                               | 22d. LOCATION (City, town, or county) (State)<br><u>Oulu, Wisconsin</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Arthur Walters</u>   |                               | ADDRESS<br><u>254 Carroll St. NW. D.C.</u>   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 15 '61</u>   |                               | 24b. REGISTRAR'S SIGNATURE<br><u>Aili M. Lehto</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

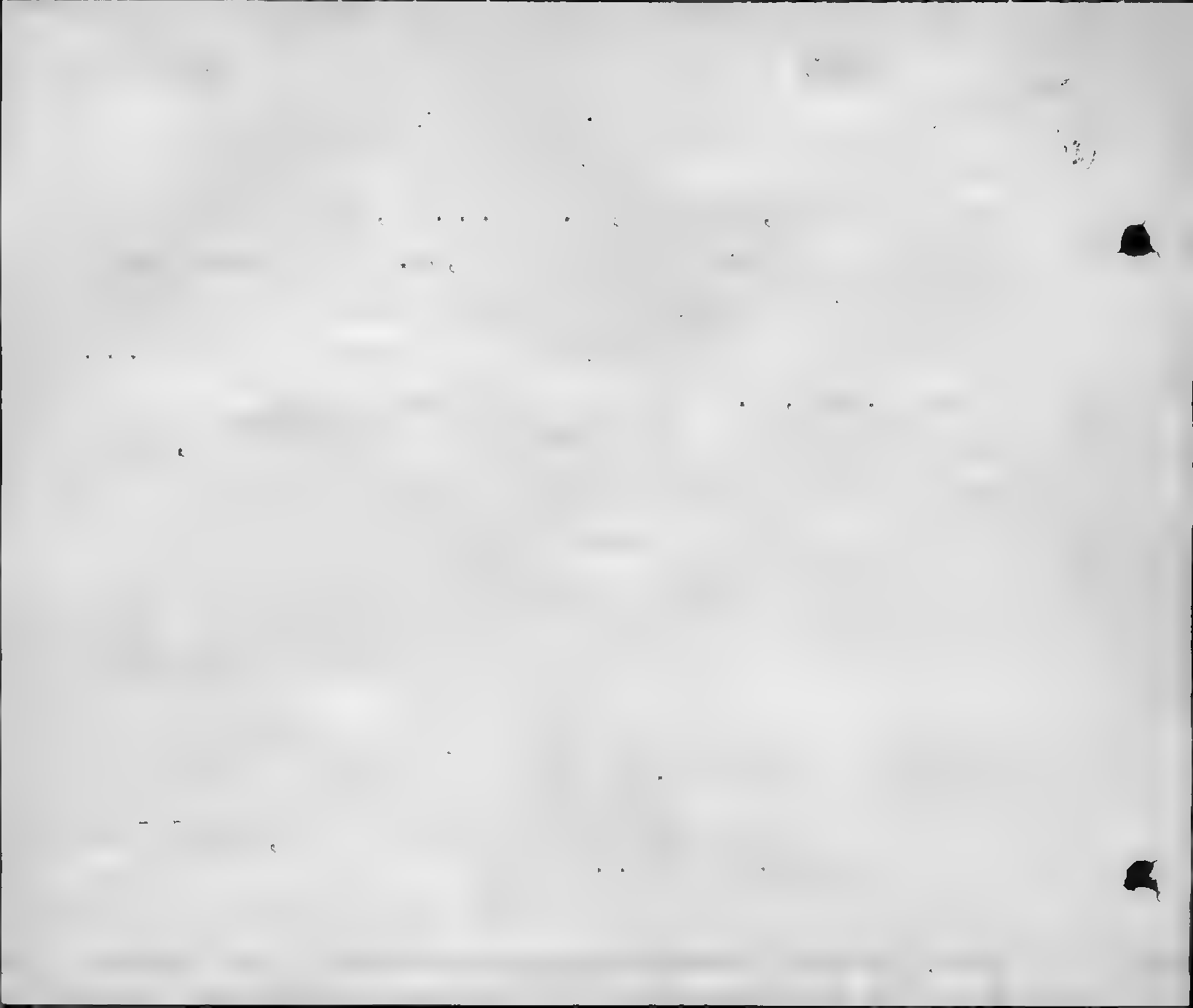
10403

## CERTIFICATE OF DEATH

10397

|  |  |   |   |
|--|--|---|---|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b><br>Montgomery   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>STATE <b>Virginia</b> COUNTY <b>Loudoun</b>   |   |
| <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda  |  | <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town)<br>Leesburg   |   |
| <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.   |  | <b>d. STREET ADDRESS</b><br>R.F.D. # 1, Box 293   |   |
| <b>3. NAME OF DECEASED</b><br>First Middle Last<br>Benjamin Franklin Leith, Jr.  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br>September 21, 1961   |   |
| <b>5. SEX</b><br>Male  | <b>6. COLOR OR RACE</b><br>White   | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br>March 31, 1882                                   |
| <b>9. AGE</b> (In years last birthday)<br>79 yrs.  |  | <b>10. FUNDING YEAR</b><br>Months Days Hours M.n.<br>79   |   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Farmer   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>Agriculture   |   |
| <b>11. BIRTHPLACE</b> County & State or foreign country<br>Virginia  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.   |   |
| <b>13. FATHER'S NAME</b><br>Benjamin F. Leith, Sr.   |  | <b>14. MOTHER'S MAIDEN NAME</b><br>Levenia Francis  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war and dates of service)<br>No   |  | <b>16. SOCIAL SECURITY NO.</b><br>None  |   |
| <b>17. INFORMANT</b><br>The Medical Record   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic myelogenous leukemia<br>(b) arteriosclerotic cardiovascular disease<br>(c) Pulmonary emphysema |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m.<br>19   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   | <b>20f. (City or town) (County) (State)</b>                                 |
| <b>21. I certify that (I) (this hospital) attended the deceased from July 17, 1961 to September 21, 1961 that (I) (we) last saw the deceased alive on September 21, 1961, and that death occurred at 6:15 AM from the causes and on the date stated above.</b> |  |   |   |
| <b>22a. SIGNATURE</b><br>Louis M. Aledort M.D.   |  | <b>22b. DATE SIGNED</b><br>9-21-61  |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br>Louis M. Aledort M.D.   |  | <b>22d. LOCATION</b> (City, town or county) (State)<br>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>Burial   | <b>23b. DATE THEREOF</b><br>9-23-61  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>Middleburg, Virginia   | <b>23d. LOCATION</b> (City, town or county) (State)<br>Middleburg, Virginia |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br>Louis R. Rypstra  |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE SEP 26 '61   | <b>25b. REGISTRAR'S SIGNATURE</b><br>Arthur S. Kline                        |

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE FILED WITHIN 24 HOURS AFTER DEATH. THE DEATH CERTIFICATE MAY BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETED, IT SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.



8 1  
FOR STATE  
HEALTH DEPT.

Item 18 Film 298 10-26-61  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**10404 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10398**

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>mntg</u>                        |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |   |  |
| c. LENGTH OF STAY IN 1b <u>3 yrs</u>  |  |   |  | d. STREET ADDRESS <u>111 Lee St. Apt 406</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Joseph Ray Lilley</u>  |  |   |  | 4. DATE OF DEATH <u>Sept 23 1961</u>   |  |   |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>white</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>10-8-1902</u>                             |  |
| 9. AGE (In years last birthday) <u>59 yrs</u>   |  | 10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Pipe organ builder</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Pa</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>                     |  |
| 13. FATHER'S NAME <u>J. P. Lilley</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Edith Wagner</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>  |  |   |  | 16. SOCIAL SECURITY NO. <u></u>  |  | 17. INFORMANT <u>Maud Lilley (wife)</u> Address <u>Stem 2</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u><br>DUE TO (b) <u></u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, <u></u><br>DUE TO (c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18) <u></u>  |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>   |  | 20f. (City or town) (County) (State) <u></u>                  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |   |  | 22b. DATE THEREOF <u>SEPT 27, 1961</u>   |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>257 Carroll St NW</u>   |  |   |  | 22d. LOCATION (City, town, or country) (State) <u>BLOOMSBURG, Pa.</u>  |  |   |  |
| 23. FUNERAL DIRECTOR <u>Harold J. Teller</u>  |  |   |  | 24a. REC'D BY REGISTRAR <u>SEP 26 '61</u>  |  |   |  |
| 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>  |  |   |  |  |  |   |  |

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

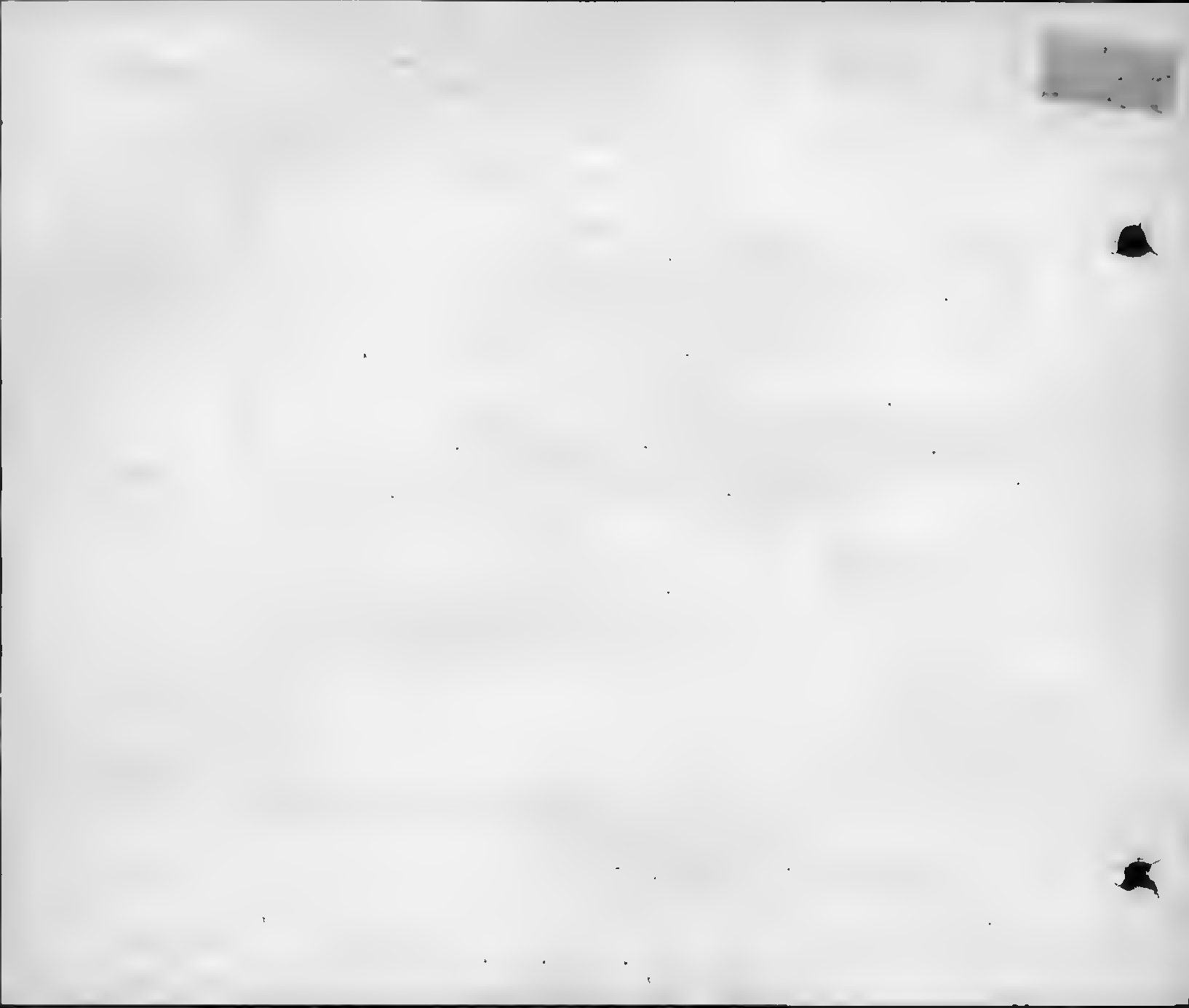
Item 8 filed 9/18/61 ink

## CERTIFICATE OF DEATH

Items 4 & 5 filed 9/20/61 ink

Reg. # 10899

|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rockville                    |  | c. LENGTH OF STAY IN 1b<br>12  |  | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE<br>b. COUNTY<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rockville  |  | d. STREET ADDRESS<br>13221 Foxden Drive  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>William G. Little  |  | 4. DATE OF DEATH<br>Month Day Year<br>September 13, 1961                                     |  | 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>White  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>9/13/1917  |  | 9. AGE (In years last birthday)<br>44  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Sales Store   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Sales Store   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>US   |  | 13. FATHER'S NAME<br>Newman G. Little  |  | 14. MOTHER'S MAIDEN NAME<br>Luraner Manne  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>yes  |  | 16. SOCIAL SECURITY NO.<br>579-10-6573  |  |
| 17. INFORMANT<br>William M. Little - Son   |  | Address  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CORONARY THROMBOSIS<br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) ARTERIAL HYPERTENSION<br>(c) ARTERIO-SCLEROSIS |  | INTERVAL BETWEEN ONSET AND DEATH<br>Two Hours<br>15 YEARS<br>15 YEARS  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                           |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town)<br>Rockville   |  | (County)<br>Montgomery   |  | (State)<br>Maryland  |  | 21. I certify that I attended the deceased from Sept 7, 1961, to Sept 13, 1961, that I last saw the deceased alive on Sept 13, 1961, and that death occurred at 6 A. M. from the causes and on the date stated above |  | ADDRESS (Street, city or town, state)<br>310 W. MONITORING RD. Rockville, Md.   |  |
| 21. ACTUAL SIGNATURE<br>Gordon S. Rosenberger, M.D.  |  | DATE SIGNED<br>Sept 13, 1961   |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF<br>9/15/61   |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Rockville   |  |
| 22d. LOCATION (City, town, or county)<br>Rockville, Md.  |  | (State)<br>Maryland  |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br>Arthur S. Manne  |  | ADDRESS<br>13221 Foxden Drive  |  | 24a. REC'D BY REGISTRAR<br>DATE SEP 15 '61  |  |
| 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Manne  |  |  |  |  |  |  |  |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

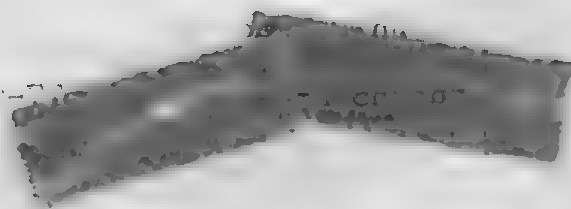
10406

10400

| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u><br>c. LENGTH OF STAY (N 1b) <u>28 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u> |      |  |      | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if not before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u><br>d. STREET ADDRESS <u>Route #1</u> |  |  |  |              |  |                  |  |        |      |       |      |
|--|------|--|------|---|--|--|--|--------------|--|------------------|--|--------|------|-------|------|
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Ronald Chase Mac Nab</u>  |      |  |      | <b>4. DATE OF DEATH</b><br>Month <u>9-</u> Day <u>30</u> Year <u>19 61</u>  |  |  |  |              |  |                  |  |        |      |       |      |
| <b>5. SEX</b><br><u>male</u>   |      | <b>6. COLOR OR RACE</b><br><u>white</u>  |      | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>9-21-03</u>  |  | <b>9. AGE</b> (In years - last birthday) <u>58</u> yrs. <table border="1"> <tr> <th colspan="2">UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> |  | UNDER 1 YEAR |  | IF UNDER 24 HRS. |  | Months | Days | Hours | Min. |
| UNDER 1 YEAR   |      | IF UNDER 24 HRS.   |      |   |  |  |  |              |  |                  |  |        |      |       |      |
| Months   | Days | Hours  | Min. |   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>patent attorney</u>  |      |  |      | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U. S. Air Force</u>   |  | <b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Washington, D. C.</u>   |  |              |  |                  |  |        |      |       |      |
| <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |      |  |      | <b>13. FATHER'S NAME</b> <u>John F. Mac Nab</u>   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>14. MOTHER'S MAIDEN NAME</b> <u>Nellie Carter</u>   |      |  |      | <b>15. SOCIAL SECURITY NO.</b> <u>577-09-5484</u>   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>16. INTERMEDIATE CAUSE</b> <u>Metastatic Carcinoma of Brain</u>   |      |  |      | <b>17. MEDICAL EXAMINER'S SIGNATURE</b> <u>Dr. G. F. Meadors, M. D.</u>   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>18. MEDICAL CERTIFICATION</b><br>PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Primary Carcinoma of right lung</u>  |      |  |      | <b>19. INTERVAL BETWEEN ONSET AND DEATH</b><br><u>3 months</u><br><u>1 to 2 years</u>   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><u>19</u>   |      |  |      | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)<br><u>19</u>   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m.   |      | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |      | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)  |  |              |  |                  |  |        |      |       |      |
| <b>21. I certify that (I) the deceased</b> attended the deceased from <u>1955</u> to <u>Sept. 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 30, 1961</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.   |      |  |      |   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>22a. SIGNATURE</b><br><u>Dr. G. F. Meadors, M. D.</u>   |      |  |      | <b>22b. DATE SIGNED</b><br><u>10/2/61</u>   |  |  |  |              |  |                  |  |        |      |       |      |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Dr. G. F. Meadors, M. D.</u>   |      |  |      | <b>22d. ADDRESS</b><br><u>DAMASCUS, MD</u>  |  |  |  |              |  |                  |  |        |      |       |      |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |      | <b>23b. DATE THEREOF</b><br><u>Oct. 3, 1961</u>  |      | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Rock Creek</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Washington, D.C.</u>   |  |              |  |                  |  |        |      |       |      |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Chas. L. H. H. H.</u>  |      |  |      | <b>25a. REC'D BY REGISTRAR</b><br><u>OCT 4 '61</u>  |  |  |  |              |  |                  |  |        |      |       |      |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Chas. L. H. H. H.</u>  |      |  |      | <b>25c. DATE</b><br><u>OCT 4 '61</u>  |  |  |  |              |  |                  |  |        |      |       |      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60





## CERTIFICATE OF DEATH

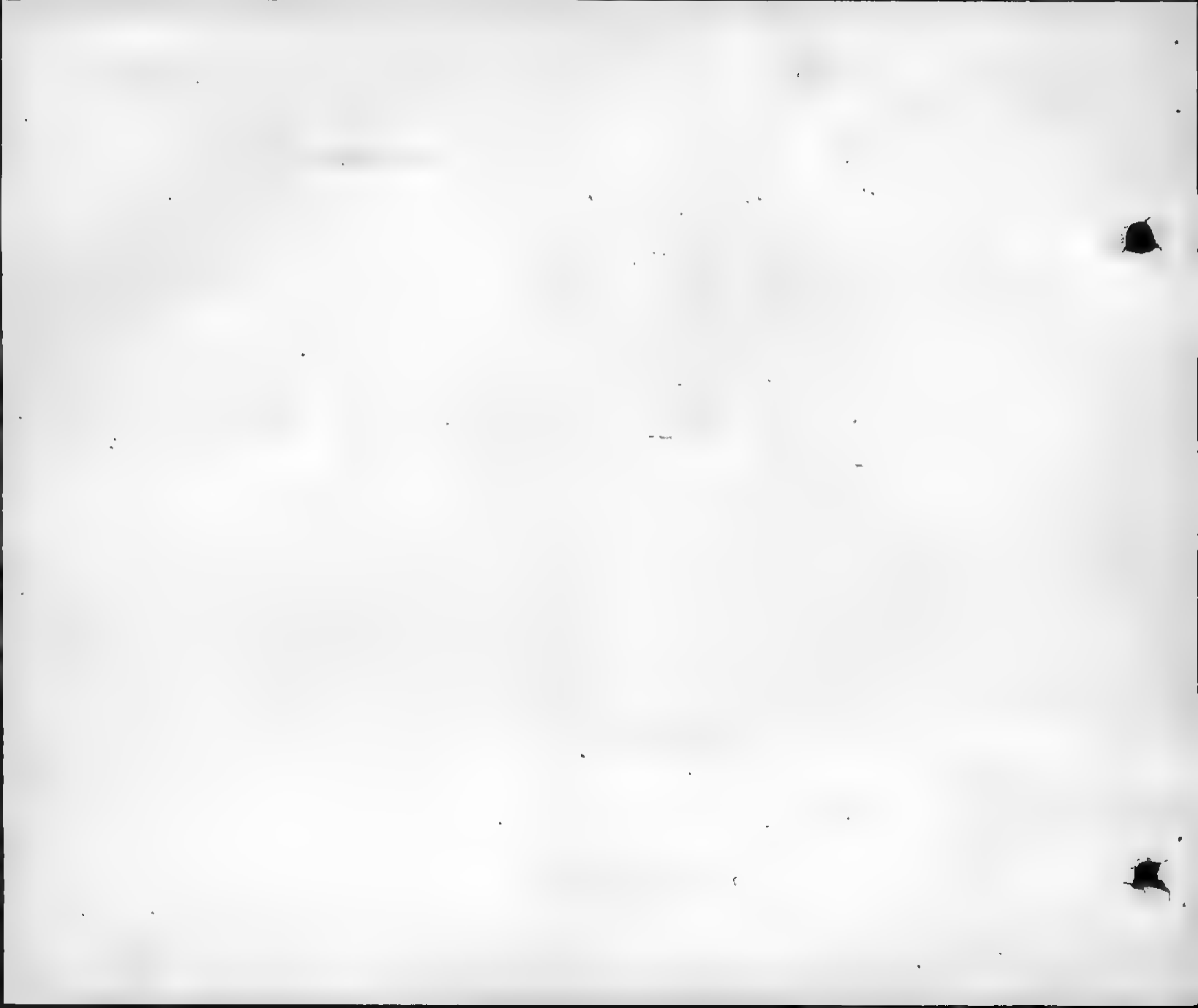
Reg. Dist. No.

10407

10407

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived If institution—residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON, D.C.</b>        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WASHINGTON, D.C.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Bel Pre Nursing Home</b>  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SARAH</b> Middle <b>APPLESTEIN</b> Last <b>MARKOWITZ</b>   |                                     | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>19</b> Year <b>1961</b>  |   |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b>           | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 1, 1896</b>                                  |
| 9. AGE (In years last birthday) <b>65</b> yrs.   |                                     | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>TRENTON-NEW JERSEY</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>FRANK L. APPLESTEIN</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>IDA POTTS</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                                     | 16. SOCIAL SECURITY NO. <b>579-14-6336-A</b>   |   |
| 17. INFORMANT <b>HUSBAND</b>   |                                     | Address <b>1336 MISSOURI AVE. NW WASH. DC</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic CANCER</b><br>170x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CANCER of the Breast</b><br>DUE TO (c) <b>1 year</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month Day Year<br>Hour a. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>9/4</b> , 19 <b>61</b> , to <b>9/19</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>9/19</b> , 19 <b>61</b> , and that death occurred at <b>7 A</b> . M. from the causes and on the date stated above.  |                                     |  |   |
| ACTUAL SIGNATURE <b>MAX G. Sherer MD</b>   |                                     | ADDRESS (Street, city or town, state) <b>2025 Eye Street NW Wash DC</b>  |   |
| PHYSICIAN'S NAME (Type) <b>MAX G. SHERER, MD</b>   |                                     | DATE SIGNED <b>9/19/61</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>9-21-61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>KING DAVID MEMORIAL GARDEN</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>FALLS CHURCH VA</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Blangarsky &amp; Son</b>   |                                     | ADDRESS <b>3501-14th St. NW</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>SEP 22 1961</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Kraus</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed in the hospital or attending physician's file. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(1)

# MARYLAND STATE DEPARTMENT OF HEALTH

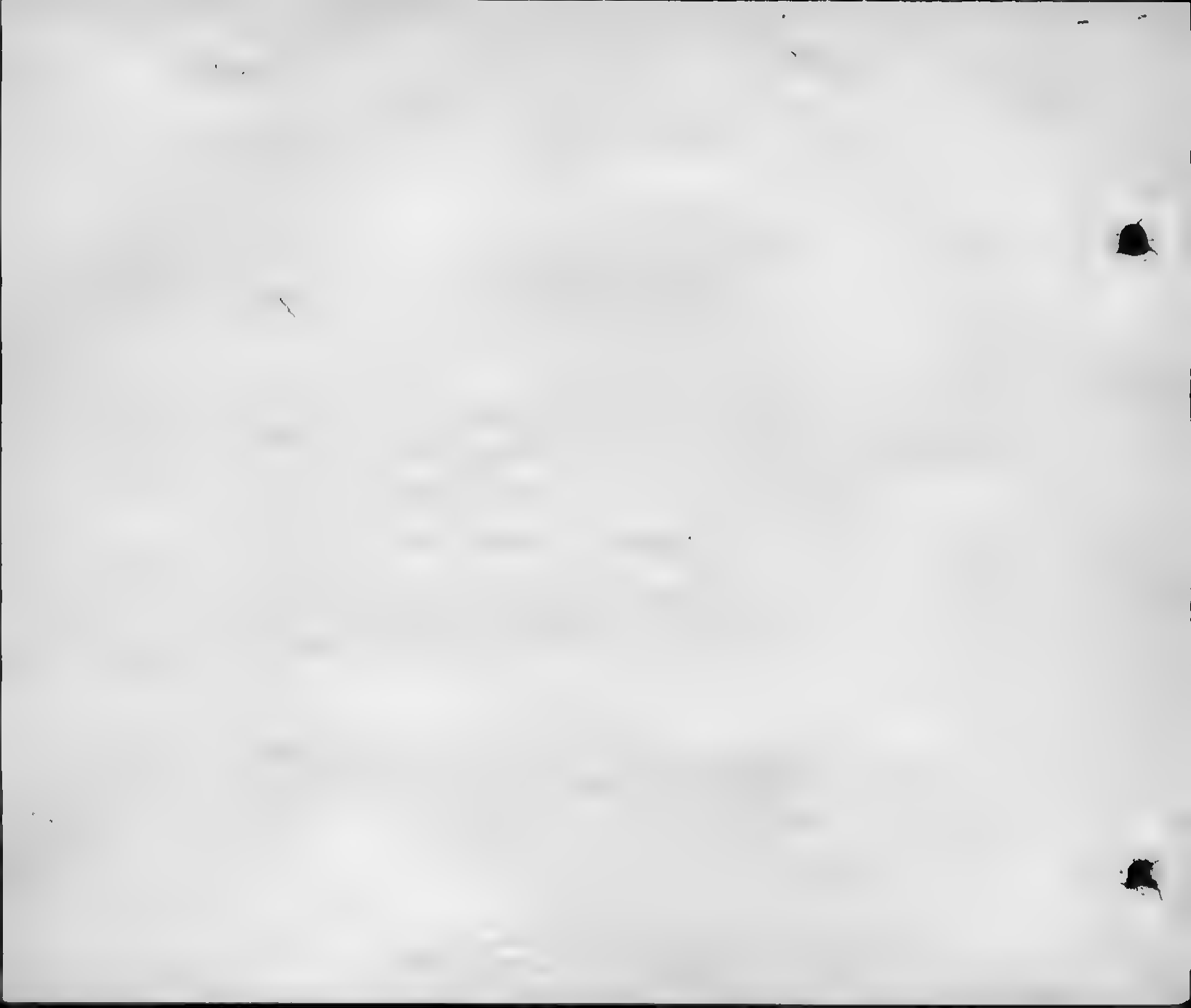
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10408

## CERTIFICATE OF DEATH

10402

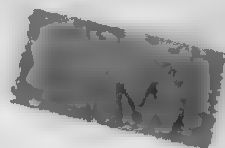
|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |  |
| c. LENGTH OF STAY in b. <u>58 days</u>  |  | d. STREET ADDRESS <u>1107 - Veers Mill Rd.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Effie Lillian Marsh</u>   |  | 4. DATE OF DEATH <u>Sept. 27</u> 19 <u>61</u>  |  |
| 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>1/19/02</u>   |  | 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>19</u> Hours <u>15</u> Min.                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |
| 13. FATHER'S NAME <u>Richard Woods</u>  |  | 14. MOTHER'S MARRIEN NAME <u>Elizabeth Breeden</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>Benjamin Marsh</u>  |  |
| 17. INFORMANT <u>Benjamin Marsh</u>   |  | Address <u>same as above</u>   |  |
| 18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c)]   |  |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u>   |  |  |  |
| (c) <u>Coronary atherosclerosis</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Diabetes mellitus</u>   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  |  |  |  |
| 20c. TIME OF INJURY: Hour a.m. <u>19</u> p.m. <u>19</u>   |  | 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town, County, State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1</u> 19 <u>61</u> to <u>Sept. 27</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Sept. 27</u> 19 <u>61</u> , and that death occurred at <u>8:30</u> M. from the causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE <u>G. Bowditch Hunter, Jr.</u>   |  | 22b. DATE SIGNED <u>9/26/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>   |  | 22d. ADDRESS <u>809 Veers Mill Rd., Rockville, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>Sept. 30, 1961</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>  |  | 23d. LOCATION (City, town or county, State) <u>Rockville, Maryland</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Japon Wheeler</u>   |  | 25a. REC'D BY REGISTRAR <u>OCT 2 '61</u>   |  |
| ADDRESS <u>1331 - E Montg. Ave. Rockville, Md.</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 10409   |  |  |  |  | 10403   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u><br>c. LENGTH OF STAY (N, M, Y) <u>4 months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3519 E Bradley Lane</u>  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Florida</u> b. COUNTY <u>Volusia</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Daytona Beach</u><br>d. STREET ADDRESS <u>464 Golf Blvd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Ann. Amos Marshall</u>  |  |  |  |  | 4. DATE OF DEATH <u>Sept 21 1961</u>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 8. DATE OF BIRTH <u>July 2 1877</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>4</u> IF UNDER 24 HRS.: Hours <u>8</u> Mins. <u>4</u>   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>  |  |  |  |  | 11. BIRTHPLACE (County & State or foreign country) <u>Uniontown Pa.</u>   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                               |  |  |  |  |   |  |  |  |  |
| 13. FATHER'S NAME <u>Jacob S. Miller</u>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Ann Amos</u>  |  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> |  |  |  |  | 16. SOCIAL SECURITY NO. <u>None</u>                                      |  |  |  |  | 17. INFORMANT <u>Frances James Marshall</u> Address <u>same</u> |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of colon</u><br>DUE TO (b) <u>—</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u><br>DUE TO (c) <u>—</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> |  |  |  |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |   |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>  |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>                                   |  |  |  |  | 20f. (City or town) (County) (State)                                     |  |  |  |  |   |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1961</u> to <u>Sept 21 1961</u> , that (I) <u>—</u> last saw the deceased alive on <u>Sept 19 1961</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.  |  |  |  |  |   |  |  |  |  | 22a. SIGNATURE <u>Allen J. O'Neill</u> M.D.   |  |  |  |  | 22b. DATE SIGNED <u>Sept 21 1961</u>                                     |  |  |  |  |   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill M.D.</u>   |  |  |  |  | 22d. ADDRESS <u>8601 Old Georgetown Rd</u>  |  |  |  |  | 22e. (City, town or county) <u>Bethesda</u>   |  |  |  |  | 22f. (State) <u>Md.</u>  |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  |  | 23b. DATE THEREOF <u>9-25-61</u>  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Cemetery</u>   |  |  |  |  | 23d. LOCATION (City, town or county) (State) <u>Winchester, Virginia</u> |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u>—</u>   |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR <u>SEP 27 '61</u>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>                        |  |  |  |  |   |  |  |  |  |



TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 shows the cause of death as used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.  
(M)

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |
| 10410  |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u> |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>2 yrs</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1017 Carson St</u>   |  |  |  | d. STREET ADDRESS <u>1017 Carson St</u>  |  |  |  | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth Mayhew</u>  |  |  |  | 4. DATE OF DEATH <u>Sept 29 1961</u>   |  |  |  | b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 5. SEX <u>Female</u>   |  |  |  | 6. COLOR OR RACE <u>White</u>  |  |  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> |  |  |  |
| 8. AGE (In years, months, days) <u>35</u>  |  |  |  | 9. AGE (In years, months, days) <u>35</u>  |  |  |  | 10. AGE (In years, months, days) <u>35</u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>Fla.</u>  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  | 13. FATHER'S NAME <u>Mardie Wells</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Edwina McIntosh</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>—</u>   |  |  |  | 17. INFORMANT <u>Myrtle Jones (sister)</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO <u>hanging</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>174X</u><br>causing the underlying cause test. (c) <u>—</u>  |  |  |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>They self by neck with clothesline in basement at home</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>—</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>7 am 9-29 1961</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 20f. (City or town) <u>Silver Spring Montg</u> (County) <u>md</u> (State) <u>md</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| DATE SIGNED <u>9-29-61</u>   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S SIGNATURE <u>Frank J. Bloesch</u>   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. BLOESCH</u>   |  |  |  |  |  |  |  |  |  |  |  |
| Address (Street, city, town, or county) <u>1300-N ST. NW WASH. D.C.</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. DATE THEREOF <u>OCT. 3/61</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM.</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. LOCATION (City, town, or country) <u>ARLINGTON, VA</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR <u>HYSONG FUNERAL HOME</u>  |  |  |  |  |  |  |  |  |  |  |  |
| ADDRESS <u>1300-N ST. NW WASH. D.C.</u>  |  |  |  |  |  |  |  |  |  |  |  |
| 24a. REC'D BY REGISTRAR <u>—</u>   |  |  |  |  |  |  |  |  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knies</u>  |  |  |  |  |  |  |  |  |  |  |  |
| DATE <u>OCT 2 '61</u>  |  |  |  |  |  |  |  |  |  |  |  |

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".



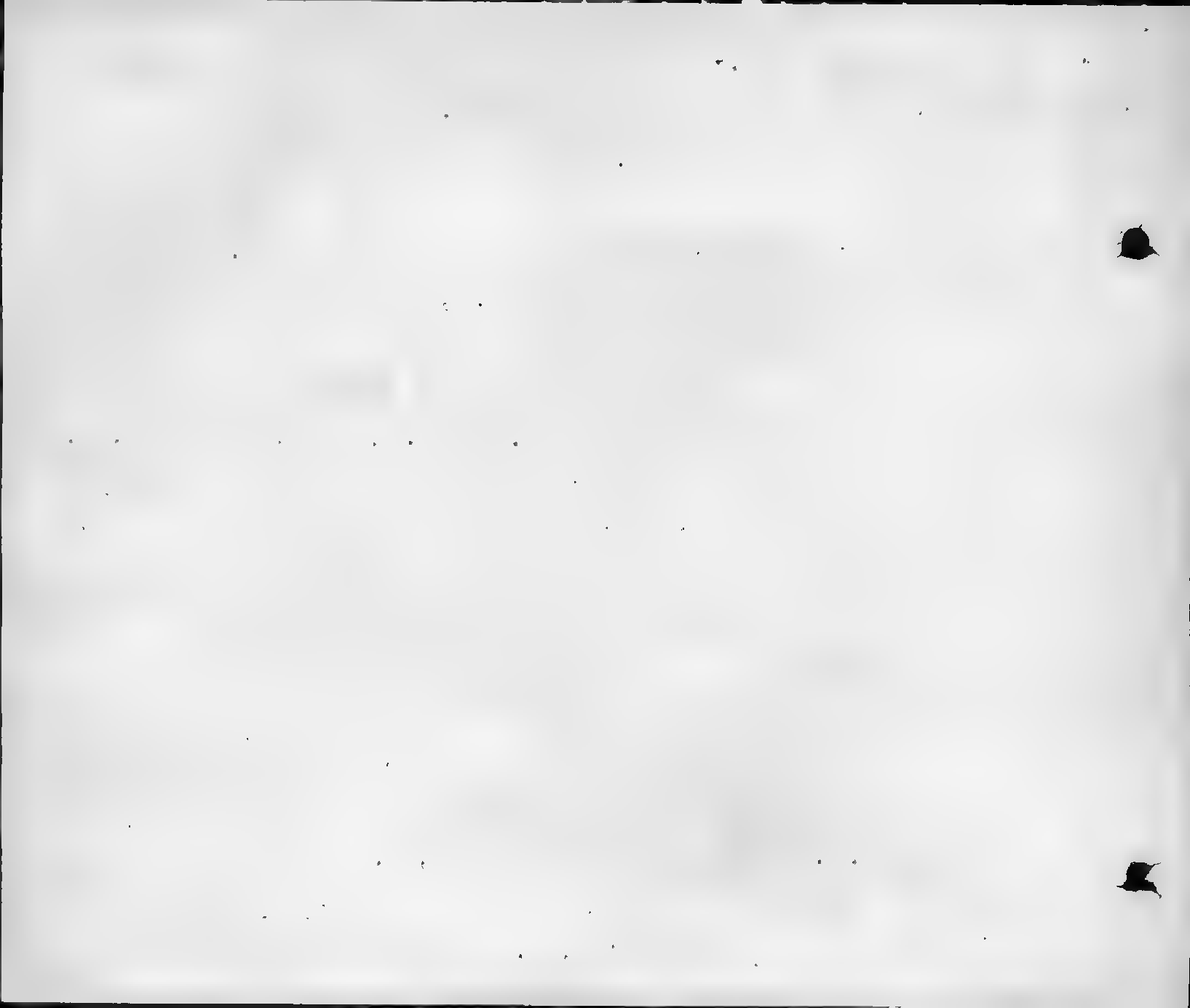
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10411

10405

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ashton</b>   |   | c. LENGTH OF STAY IN 1b<br><b>10 yr.</b>  |  | X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ashton</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   |   | d. STREET ADDRESS<br><b>1</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Everard</b> Last <b>McCarty</b>  |   |   | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>4</b> Year <b>1961</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 1, 1884</b>  | 9. AGE (In years last birthday)<br><b>76</b> yrs   | IF UNDER 1 YEAR<br>Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer (Retired)</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   | 13. FATHER'S NAME<br><b>Dennis McCarty</b>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Blackmore</b>   |   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)<br><b>no</b>   |  |   |
| 16. SOCIAL SECURITY NO<br><b>Unknown</b>  |   |   | 17. INFORMANT<br><b>Mrs. Nancy R. M. Thomas, Sandy Spring, Md.</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1742</b> DUE TO <b>Chemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>hypertensive Cardiovascular Disease</b><br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo.</b><br><b>yes</b> |   |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c):<br>19. WAS A POSTMORTEM PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Olney, Md.</b>   | (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>9/4</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9/1</b> , 19 <b>61</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.   |   |   |  |  |   |
| 22a. SIGNATURE<br><b>C. H. Ligon</b>  |   | 22b. DATE SIGNED<br><b>9/5/61</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>C. H. Ligon</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |   | 23b. DATE THEREOF<br><b>9/6/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View</b>   |   |
| 23d. LOCATION (City, town, or county)<br><b>Hamilton, Virginia</b>  |   | 23e. LOCATION (State)<br><b>Virginia</b>  |  | 23f. LOCATION (Country)<br><b>USA</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis H. Barber</b>  |   | 24a. ADDRESS<br><b>Laytonsville, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 7 '61</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>William S. Thomas</b>  |   | 25c. DATE<br><b>SEP 7 '61</b>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10412

CERTIFICATE OF DEATH

Reg. Dist. 104106

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>  |  |   |   | c. LENGTH OF STAY IN 1b<br><u>4 YRS</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>—   |  |   |   | d. STREET ADDRESS<br><u>9909 CAPITOL VIEW AVE</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>MINNIE E STELLE McCULLOUGH</u>   |  |   |   | II. DATE OF DEATH<br>Month Day Year<br><u>9 23 1961</u>   |  |   |  |
| 5. SEX<br><u>FEMALE</u>   |  | 6. COLOR OR RACE<br><u>WHITE</u>          |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3-24-1901</u>                                |  |
| 9. AGE (In years last birthday)<br><u>60</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>GEORGIA</u>         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>   |  |   |   |   |  |   |  |
| 13. FATHER'S NAME<br><u>FRANK MOOSE</u>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>COLLIE RICE</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>    |   | 17. INFORMANT<br><u>DOROTHY BLACK</u> Address <u>9909 CAPT VIEW AVE SIL SPRG MD</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u><br><u>3.5X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Huntington's Chorea</u><br>DUE TO (c) —<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hours</u><br><u>5 years</u> |  |   |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   |   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Hour a. g. p. m. Month, Day, Year<br>19  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>57</u> , to <u>Sept 23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>61</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>7105 - Reggs Rd.</u> DATE SIGNED <u>9/23/61</u><br>ACTUAL SIGNATURE <u>Hayden Dwyer</u> M.D.<br>PHYSICIAN'S NAME (Type) <u>Hayden Dwyer</u>  |  |   |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>SHIP IN</u>   |  | 22b. DATE THEREOF<br><u>9-24-61</u>       |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>RIVERDALE CEMETERY</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>COLUMBUS GA</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Chambers Co</u> ADDRESS <u>1400 Calhoun St. N.W.</u>  |  |   |   | 24a. REC'D BY REGISTRAR<br><u>SEP 26 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>W. H. D. Jones</u>                 |  |

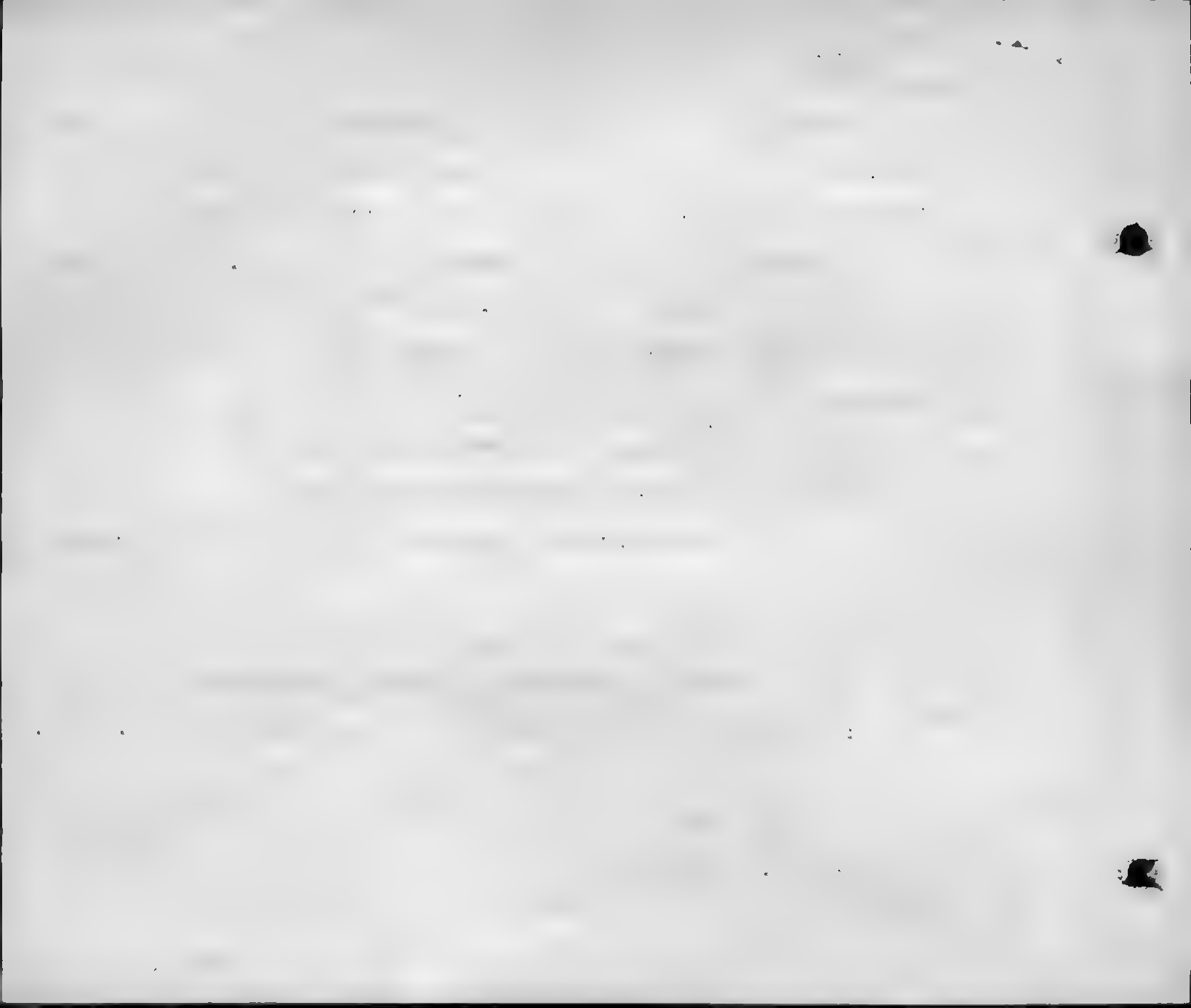


1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |  |  |  |  |  |  |  |  |
| 10413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10407  |  |  |   |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>   |  |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>                                      |  |  |   |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>  |  |  |  |  |  |
| c. LENGTH OF STAY IN <b>102 University Avenue</b>  |  |  |   |  |  | d. STREET ADDRESS <b>102 University Avenue</b>   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |  |   |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Clyde B McDannell</b>   |  |  | 4. DATE OF DEATH <b>Sept. 6 19 61</b>   |  |  | 5. SEX <b>Male</b>   |  |  | 6. COLOR OR RACE <b>White</b>  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH <b>Dec. 18, 1882</b>   |  |  | 9. AGE (In years last birthday) <b>78</b>  |  |  | 10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>61</b>                                 |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Portrait Photograph Studio Employee</b> |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>   |  |  | 11. BIRTHPLACE (State or foreign country) <b>USA</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |
| 13. FATHER'S NAME <b>Unknown</b>   |  |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>   |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |  |  |
| 17. INFORMANT <b>Employment records</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b><br>DUE TO <b>bullet wound through skull</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Sudden</b><br>(c) <b>776 X</b><br>(e), stating the underlying cause last. |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)      |  |  | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>Self inflicted bullet wound through skull</b>  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.) <b>Home</b>   |  |  | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glen Echo Montg. Md.</b> |  |  |
| 20c. TIME OF INJURY Month <b>9/6</b> Day <b>10:27</b> Year <b>19 61</b>  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glen Echo</b>  |  |  | 20f. (City or town) <b>Montg.</b>  |  |  |
| 20g. (County) <b>Md.</b>   |  |  | 20h. (State) <b>Md.</b>   |  |  | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | 22. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |
| 22a. ACTUAL SIGNATURE <b>Frank J. Broschart</b>  |  |  | 22b. DATE SIGNED <b>9/7/61</b>  |  |  | 22c. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22d. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                   |  |  |
| 22e. EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>  |  |  | 22f. ADDRESS (Street, city, town, or county) <b>Wattsburg, Pennsylvania</b>   |  |  | 22g. LOCATION (City, town, or country) <b>Wattsburg, Pennsylvania</b>  |  |  | 22h. (State) <b>Pennsylvania</b>   |  |  |
| 22i. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>   |  |  | 22j. DATE THEREOF <b>9/8/61</b>   |  |  | 22k. NAME OF CEMETERY OR CREMATORY <b>Family Burial Lot</b>  |  |  | 22l. LOCATION (City, town, or country) <b>Wattsburg, Pennsylvania</b>                              |  |  |
| 22m. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>  |  |  | 22n. ADDRESS <b>Bethesda, Maryland</b>  |  |  | 24a. REC'D BY REGISTRAR <b>SEP 8 '61</b>   |  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10414

CERTIFICATE OF DEATH

10408

Information from birth certificate

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u><br>c. LENGTH OF STAY IN b <u>4 DAYS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MONTGOMERY GENERAL HOSPITAL</u> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Carroll</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u><br>d. STREET ADDRESS <u>REMAINED IN HOSPITAL</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>RAY</u> Middle <u>NEELY</u> Last <u>McELROY, Jr.</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>SEPTEMBER</u> Day <u>7</u> Year <u>1961</u>  |  |
| <b>5. SEX</b><br><u>MALE</u>  |  | <b>6. COLOR OR RACE</b><br><u>W</u>  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>9:37A.M.</u>   |  |
| <b>9. AGE</b> (In years last birthday) <u>3</u> yrs.  |  | <b>10. BIRTHPLACE</b> (County & State, or foreign country) <u>MONTGOMERY Co., Md.</u>  |  |
| <b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  |
| <b>13. FATHER'S NAME</b><br><u>RAY NEELY McELROY, SR.</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>LOCHEIL KYLE LIVESAY</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>-</u>  |  |
| <b>17. INFORMANT</b><br><u>MOTHER</u>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>MULTIPLE CONGENITAL ABNORMALITIES</u><br><u>750X</u> <u>MOEXX</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>(ANENCEPHALIC MONSTER WITH ENCEPHALOCELE</u><br><u>MOEXX</u> } (c) <u>AND RUDIMENTARY GENITALIA)</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u><br><u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u><br>FROM BIRTH |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | <b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>  |  |
| <b>20a. TIME OF INJURY</b> Month, Day, Year <u>19</u><br>Hour a.m. <u>-</u> p.m. <u>-</u>   |  | <b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-</u>  |  | <b>20d. (City or town)</b> (County) (State)  |  |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>SEPT. 3, 1961</u> to <u>SEPT. 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 7, 1961</u> , and that death occurred at <u>11:15A.</u> from the causes and on the date stated above.                                 |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Charles S. Whitaker, M.D.</u>   |  | <b>22b. DATE SIGNED</b><br><u>SEPT. 7, 1961</u>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>CHARLES S. WHITAKER, M.D.</u>   |  | <b>22d. ADDRESS</b><br><u>CLARKSVILLE, MD.</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>9-8-61</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>McKendree Baptist</u>   |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Clarksville, Howard Co., Md.</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Arthur H. Haight</u>  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 11 '61</u>  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Wm. S. Hume</u>   |  |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET - BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

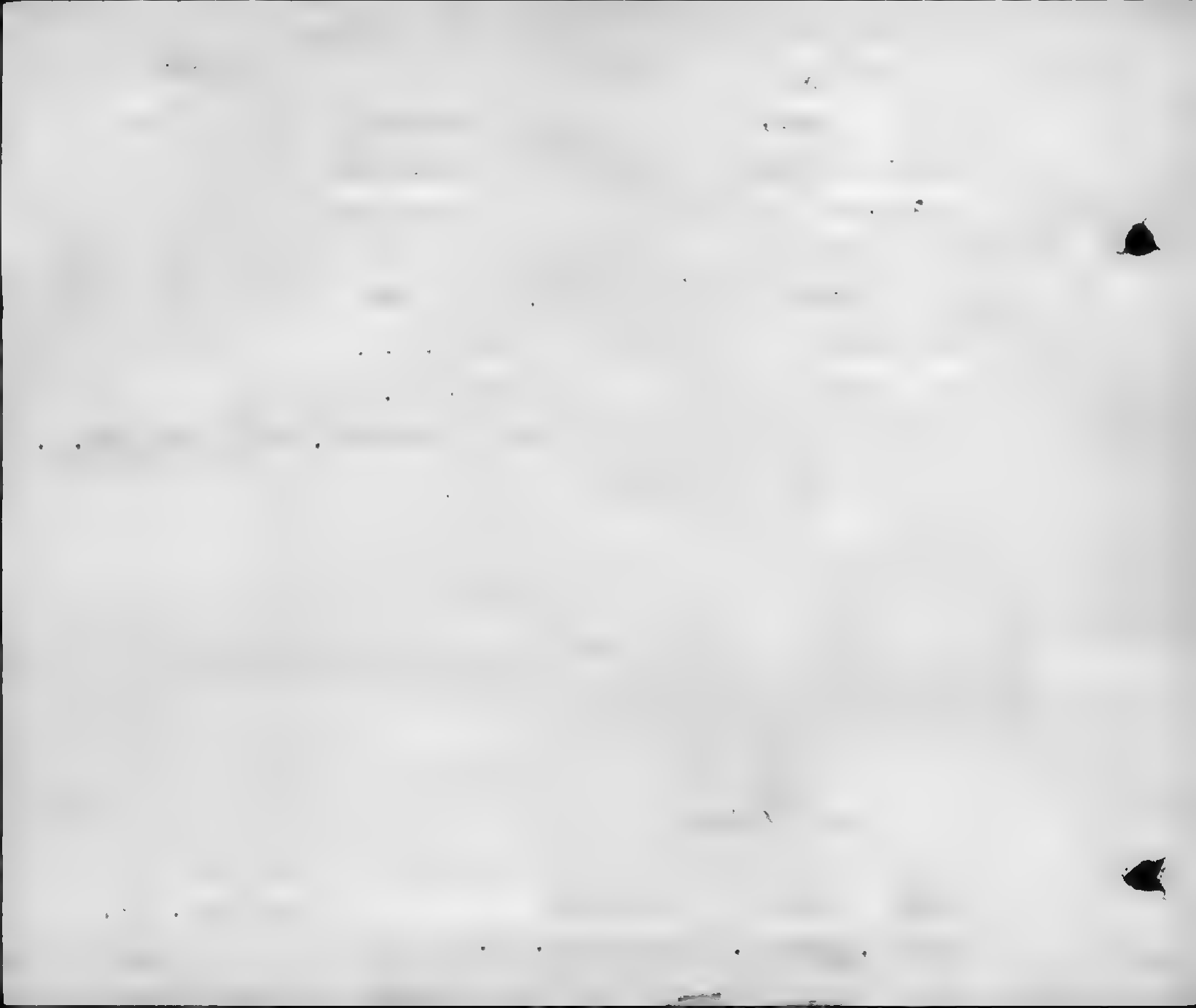
10415

10409

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montg,</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b>                                 |  |
| c. LENGTH OF STAY IN 1b <b>25 yrs</b>   |                                      | d. STREET ADDRESS <b>408 Grove Ave</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>408 Grove Ave, George Washington Mead</b>   |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>George Washington Mead</b>   | 4. DATE OF DEATH <b>Sept 6 1961</b>  | 5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>July 27-1902</b> | 9. AGE (In years last birthday) <b>59</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Comedical Clergy</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Camden, N.J.</b>   |                                      | 12. CITIZEN OF WHAT COUNTRY <b>U S A</b>   |  |
| 13. FATHER'S NAME <b>Edwin Mead</b>   |                                      | 14. MOTHER'S MAIDEN NAME <b>Sarah B. Marshall</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>  |                                      | 16. SOCIAL SECURITY NO. <b>Viola Stout Mead, Washington Grove, Md</b>  |  |
| 17. INFORMANT <b>Viola Stout Mead, Washington Grove, Md</b>   |                                      | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Heart Failure</b>   |                                      | INTERVAL BETWEEN ONSET AND DEATH   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b>   |                                      |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                                      | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year <b>1957, 19, to 9/6, 1961</b>  |                                      | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20e. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |                                      | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/28, 1961</b> , to <b>9/6, 1961</b> , that (I) (we) last saw the deceased alive on <b>8/28, 1961</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. |                                      |  |  |
| 22a. SIGNATURE <b>Luciano I. Lear</b>   |                                      | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Luciano I. Lear</b>   |                                      | 22d. ADDRESS <b>Gaithersburg, Md</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                                      | 23b. DATE THEREOF <b>9-9-61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>  |                                      | 23d. LOCATION (City, town or county) (State) <b>Gaithersburg, Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>  |                                      | 25a. REC'D BY REGISTRAR <b>SEP 8 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>   |  |

MEDICAL CERTIFICATION

TO REGISTER: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10410

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN b. 10 yrs 5  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4904 Bayard Blvd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE md b. COUNTY Montg  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 14904 Bayard Blvd

3. NAME OF DECEASED (Type or print) Kathleen C. Mead  
4. DATE OF DEATH Sept 6 1961  
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

5. SEX Female 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 8-31-'79  
9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Pa 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Patrick Conway 14. MOTHER'S MAIDEN NAME Mary O'Brien

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Mary E Mead (daughter) Address Flux 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 420 Coronary occlusion DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO  
(c) Hypertension  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None

19. INTERVAL BETWEEN ONSET AND DEATH Sudden  
yes  
yes

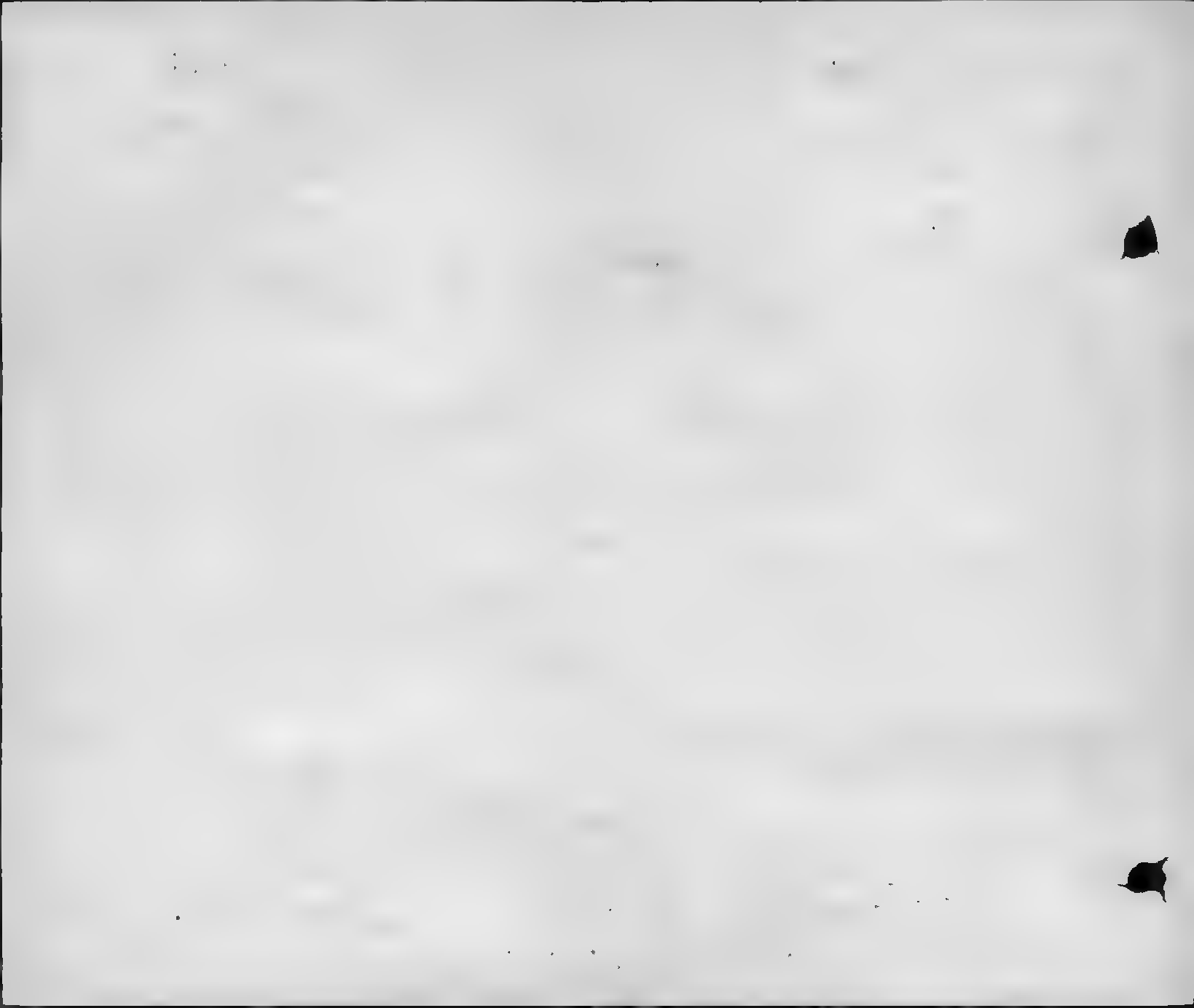
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None 20f. (City or town) None (County) None (State) None

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brosch M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) FRANK J. Brosch ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 9-6-61  
Address (Street, city, town, or county) None

22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 9/9/61 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. 22d. LOCATION (City, town, or county) Montgomery Co., Maryland

23. FUNERAL DIRECTOR The S.H.Hines Co., 2901 14th St. N.W., Wash, D.C. ADDRESS None 24a. REC'D BY REGISTRAR SEP 7 '61 24b. REGISTRAR'S SIGNATURE Charles E. Hines



2 1-3  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10411

10411

1. PLACE OF DEATH  
COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN 1b DOA.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hotel

2. USUAL RESIDENCE (Where deceased lived, if not in 1b, residence before admission)  
a. STATE Penn. b. COUNTY York Co.  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hanover  
d. STREET ADDRESS Box 214 RD 5.

3. NAME OF DECEASED  
(Type or print) Stewart Preston Mehring

4. DATE OF DEATH  
Month 9 Day 25 Year 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 9-28-94 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months 6 Days 6 IF UNDER 24 HRS: Hours 6 Min 6

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Animal Farm owner. 10b. KIND OF BUSINESS OR INDUSTRY Maryland. 11. BIRTHPLACE (State or foreign country) US. 12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME Albert T Mehring 14. MOTHER'S MAIDEN NAME Mary Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 16. SOCIAL SECURITY NO. WW1 17. INFORMANT Mrs Myrthe Mehring - Wife. Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion  
Conditions, if any, which gave rise to immediate cause (b)   
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) History of previous heart disease

20a. EXTERNAL CAUSE, WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH. ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town)  (County)  (State)

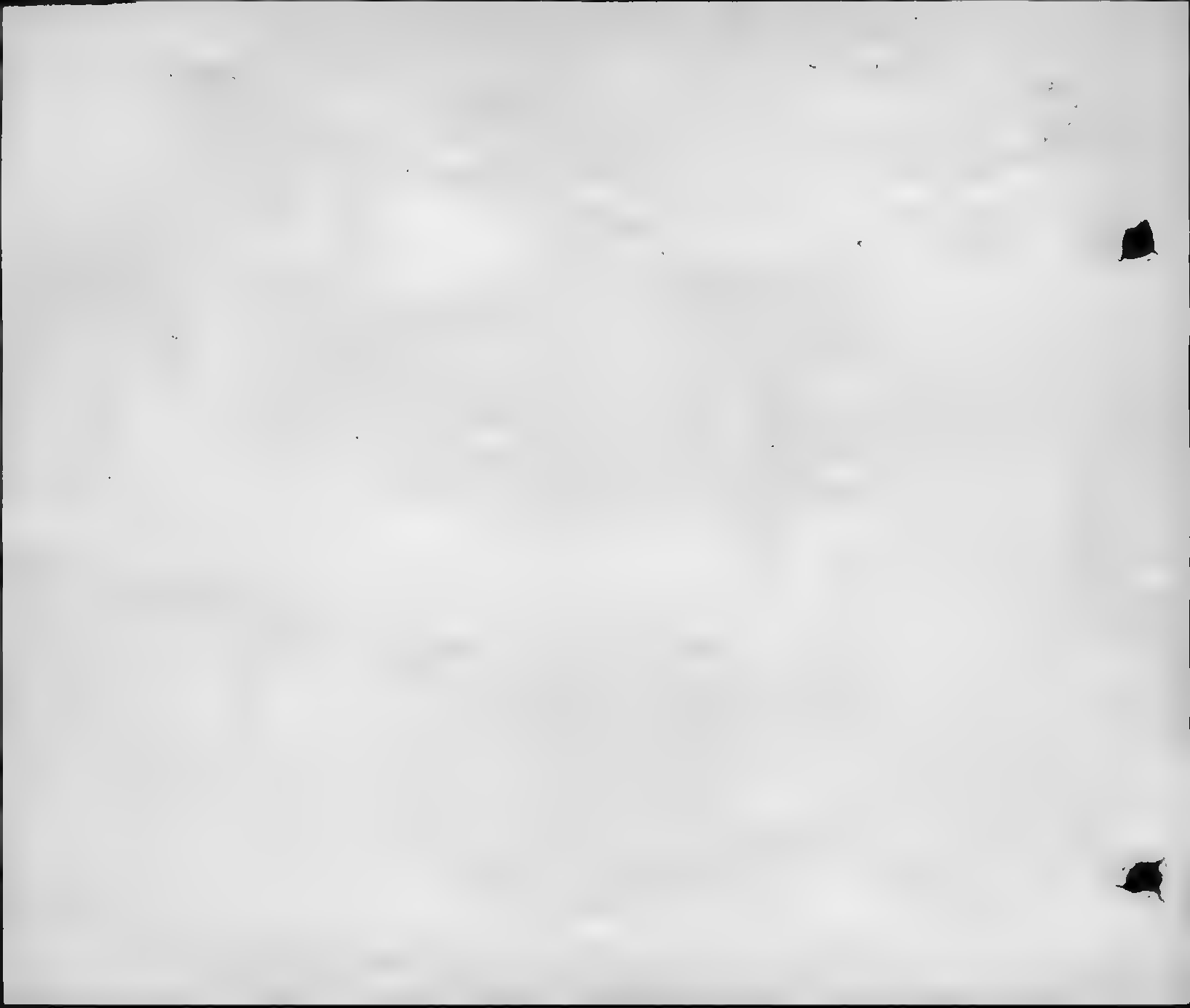
21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brosch M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 9-25-61

EXAMINER'S NAME (Type) FRANK J. Brosch Address (Street, city, town, or county) Hanover, Pa.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-28-61 22c. NAME OF CEMETERY OR CREMATORY Int. Christ Cemetery 22d. LOCATION (City, town, or county) (State) Hanover, Pa.

23. FUNERAL DIRECTOR Dennis R. Wetzel ADDRESS Hanover, Pa. 24a. REC'D BY REGISTRAR SEP 28 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
M  
10418  
10412  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Oklahoma</b>        |  | b. COUNTY<br><b>Altus</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  | c. LENGTH OF STAY IN 1b<br><b>21 Days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Altus Air Force Base</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center</b>   |  | d. STREET ADDRESS<br><b>249 Dogwood Drive</b>   |  | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ELLEN (NONE) MILLS</b>  |  | 4. DATE OF DEATH<br><b>September 19, 1961</b>   |  | 5. AGE (In years last birthday)<br><b>3 yrs.</b>   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Formosa</b>  |  |
| 13. FATHER'S NAME<br><b>Harold F. Mills</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Beaver</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>The Medical Record</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsia Partialis Continua</b> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>None</b>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>                 |  | 20c. TIME OF INJURY<br>Month, Day, Year<br><b>August 29, 1961</b>  |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>The Clinical Center, Bethesda 14, Maryland</b> |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August 29, 1961</b> to <b>Sept. 19, 1961</b> that (I) (we) last saw the deceased alive on <b>Sept. 19, 1961</b> and that death occurred at <b>11:25 a.m.</b> The causes and on the date stated above.   |  | 22a. SIGNATURE<br><b>JAMES C. DAVIE</b>   |  | 22b. DATE SIGNED<br><b>9/20/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JAMES C. DAVIE, M.D.</b>  |  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>                                 |  | 22e. LOCATION (City, town or county) (State)<br><b>Salisbury North Carolina</b>  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>23 SEPT. 1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>816 HST, NE, WASH 2, DC</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Michael Thaddeus</b>  |  | 25a. REGISTRAR'S SIGNATURE<br><b>SEP 28 1961</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>SEP 28 1961</b>   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10419

## CERTIFICATE OF DEATH

10413

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

9506 Ewing Drive

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

9506 Ewing Drive

a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

Bertrand

First Middle Last

L

Moffett

DATE OF DEATH

Sept.

Day

20

Year

19 61

### 5. SEX

Male

### 6. COLOR OR RACE

White

### 7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

### 8. DATE OF BIRTH

Aug. 29, 1925

### 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.)

36 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Real Estate & Ins.

10b. KIND OF BUSINESS OR INDUSTRY

Real Estate

11. BIRTHPLACE (Country & State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

### 13. FATHER'S NAME

Lee Moffett

### 14. MOTHER'S MAIDEN NAME

Alma Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.; 17. INFORMATION

Yes

Unknown

EDWARD LEWIS JR., MD.  
5800 BEECH AVE., BETHESDA, MD.

### 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

754.6

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CHRONIC ATRIAL FIBRILLATION

(c) COARCTATION OF AORTA MYOCARDIAL AND PULMONARY FIBROSIS.

INTERVAL BETWEEN ONSET AND DEATH

8 HOURS

SEVERAL YEARS

CONGENITAL

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 1955 to SEP. 20, 1961, that (I) saw the deceased alive on SEPT. 20, 1961, and that death occurred at 7:57 P.M. from the causes and on the date stated above.

### 22a. SIGNATURE

Edward Lewis Jr.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

9-20-61

### 22c. PHYSICIAN'S NAME (Type)

EDWARD LEWIS, JR., MD 5800 BEECH AVE, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

9/22/61

23c. NAME OF CEMETERY OR CREMATORY

Parklawn Cemetery

23d. LOCATION (City, town or county)

Rockville, Maryland

### 24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR

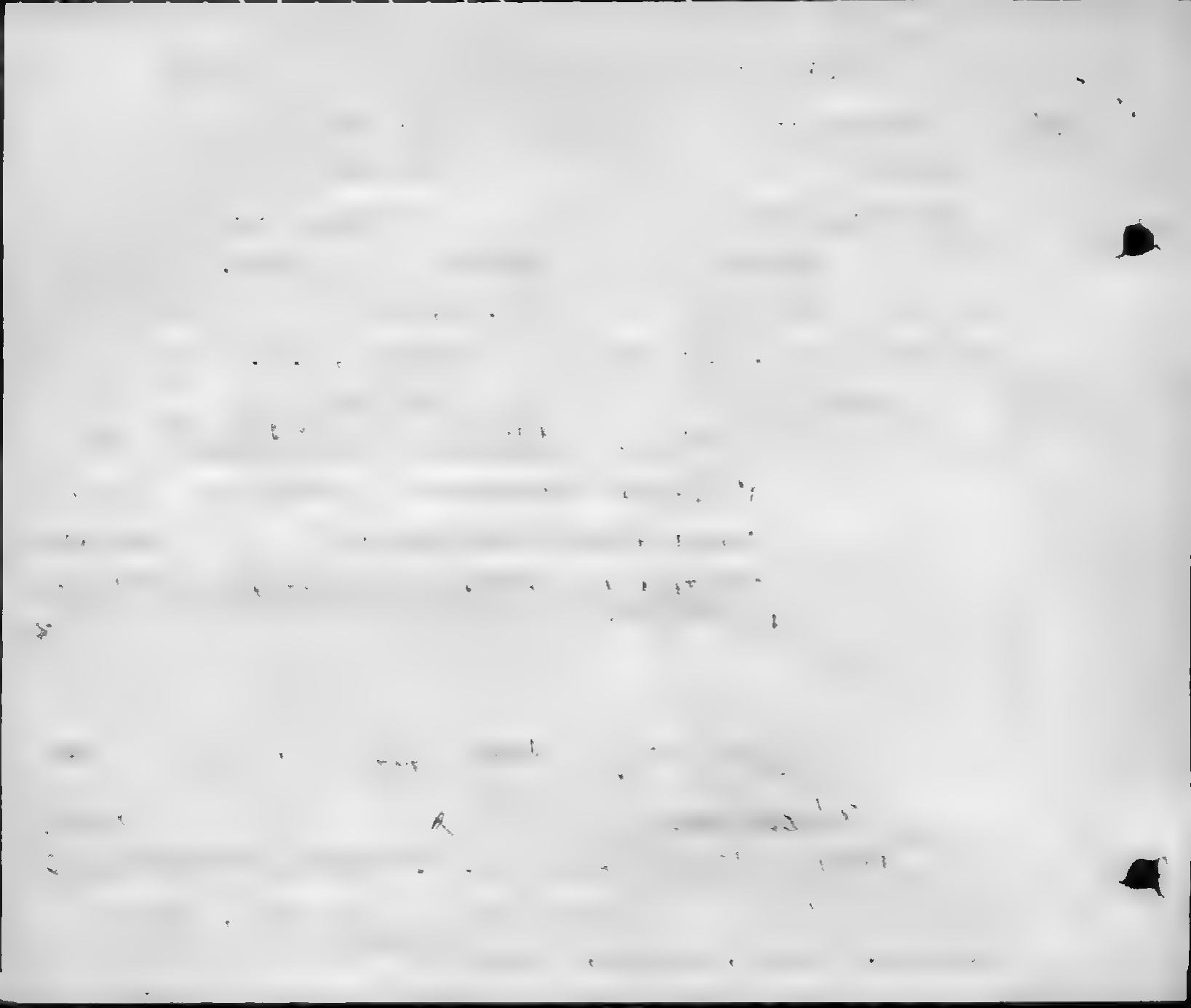
SEP 25 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Hanna

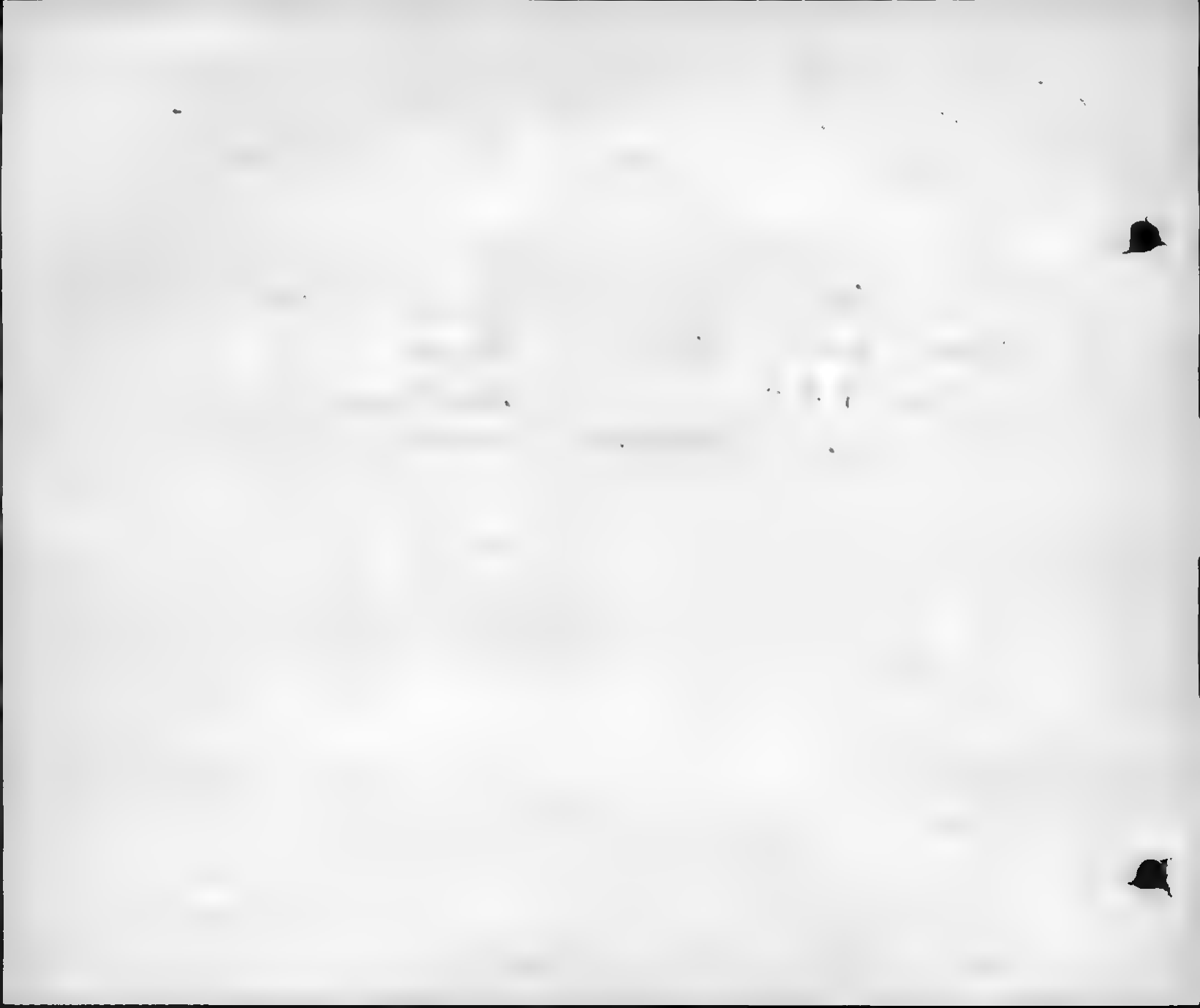
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60



## CERTIFICATE OF DEATH

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Springs, Md.</b><br>c. LENGTH OF STAY IN lb <b>16 yrs.</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Springs, Md.</b><br>d. STREET ADDRESS <b>1</b><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Thomas T Mott</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Sept</b> Day <b>12</b> Year <b>1961</b>   |  |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH <b>May 2, 1891</b>                |
| 9. AGE (In years last birthday) <b>70</b>   |                                  | 10. IF UNDER 1 YEAR: Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial Banker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Finance</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Alabama</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Joseph K. Mott</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>Mary Campbell</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>  |                                  | 16. SOCIAL SECURITY NO. <b>578-03-7207</b>   |  |
| 17. INFORMANT <b>SON - Thomas T. Mott, Jr. - Bethesda, Md</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio myocardial degeneration</b><br><b>260X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic myocarditis</b><br>DUE TO (c) <b>Ischaemic heart disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>5 yrs</b><br><b>10 yrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June</b> , 19 <b>54</b> , to <b>Sept</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Sept 10</b> , 19 <b>61</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <b>A. D. Bonifant</b>  |                                  | ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED <b>9/12/61</b>  |  |
| PHYSICIAN'S NAME (Type) <b>A. D. Bonifant</b>   |                                  | <b>Sandy Spring, Maryland</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>9/15/61</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Friends Meeting House, Cem. Sandy Spring, Md.</b>  | 22d. LOCATION (City, town, or county) (State)      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                  | 24a. REC'D BY REGISTRAR <b>SEP 18 '61</b>  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b> |



1  
FOR STATE  
HEALTH DEPT.

(M)

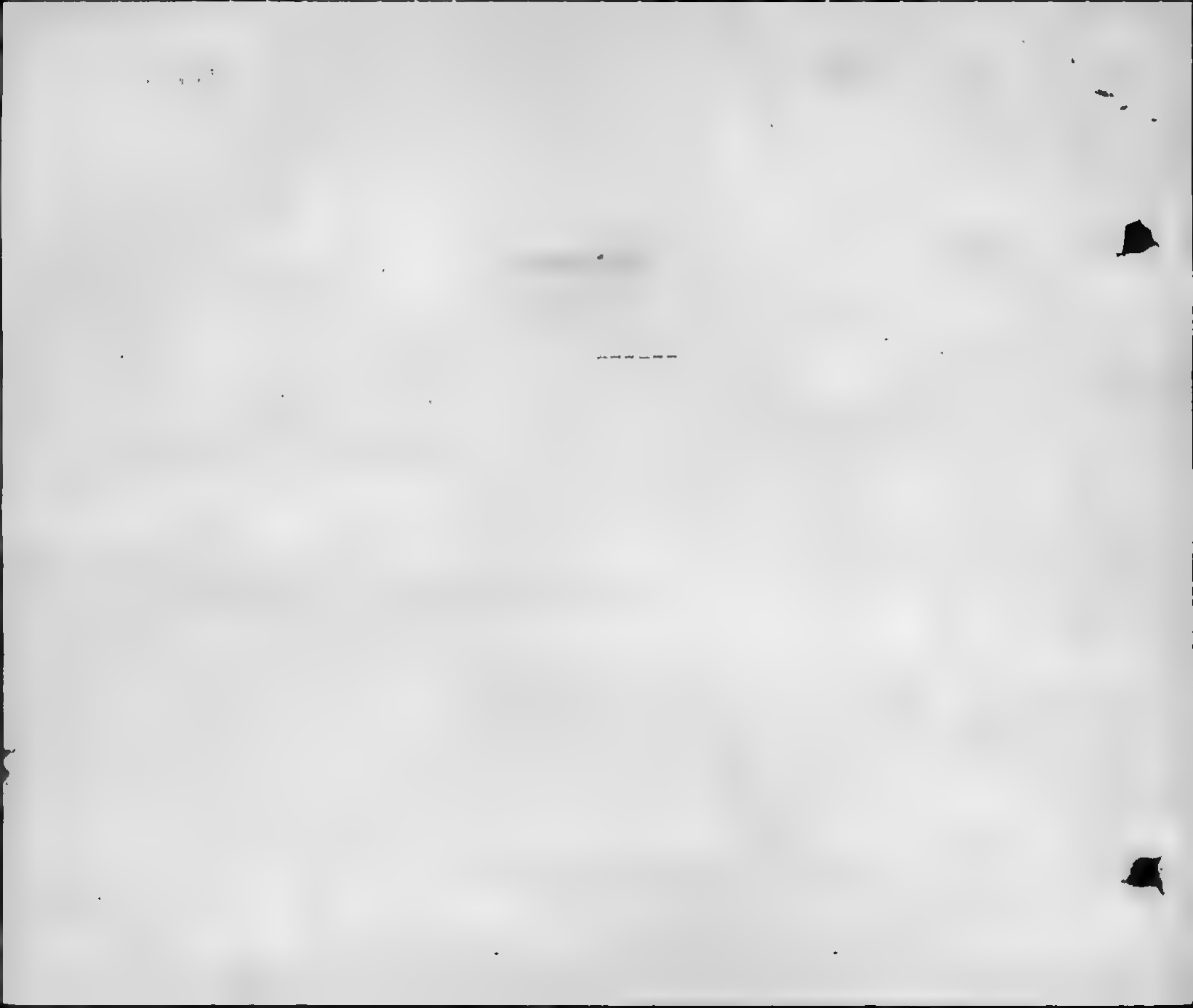
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

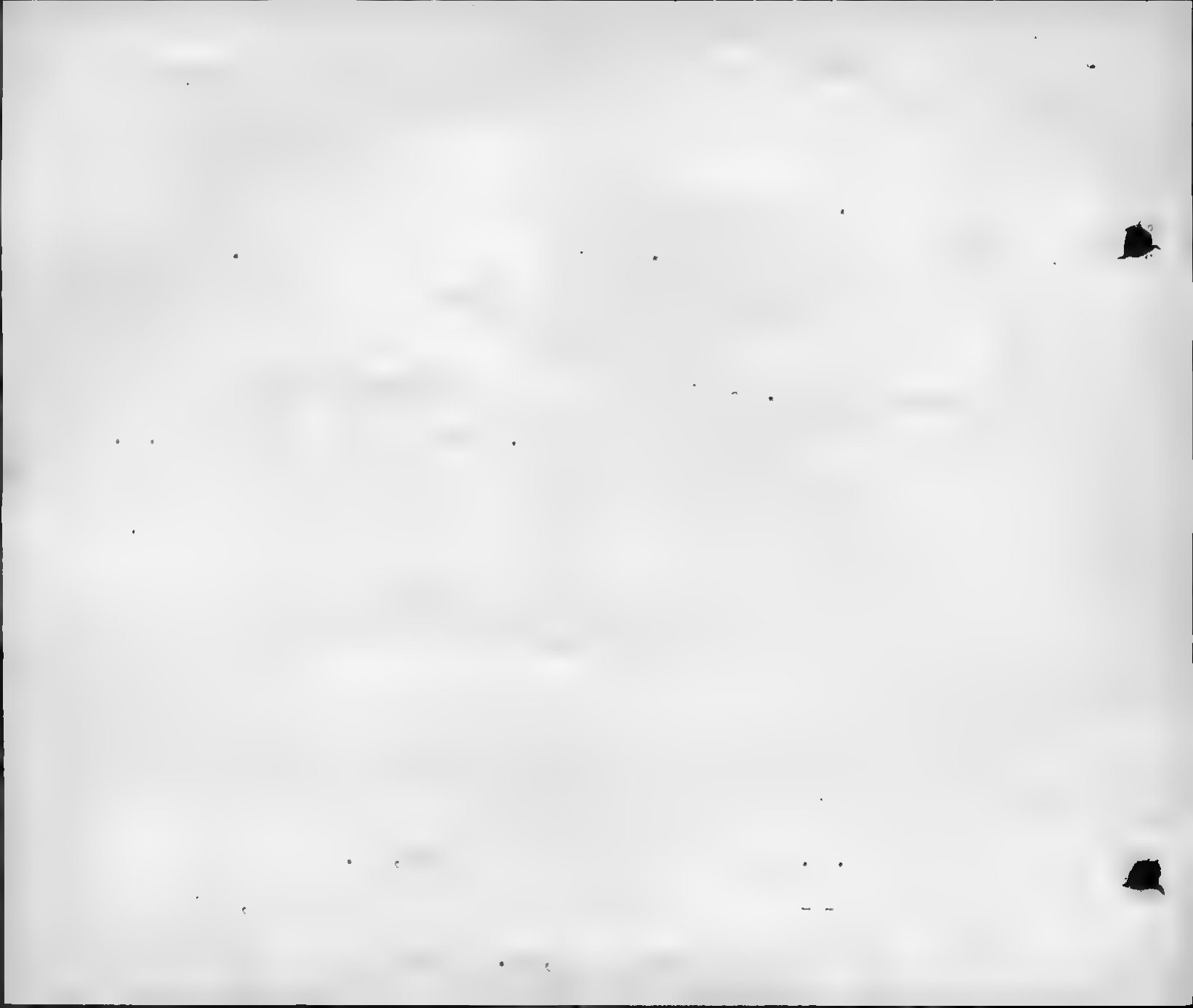
10421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10415

|   |                               |   |                                  |
|---|-------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution. Res. since before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>                          |                                  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Great Falls</u>   |                               | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>  |                                  |
| c. LENGTH OF STAY in 1b <u>DOA</u>  |                               | d. STREET ADDRESS <u>3240 Hiott Pl. N.W.</u>  |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deaiths Blind</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |
| 3. NAME OF DECEASED (Type or print) <u>B. DOMINIQUE MULTRIER</u>  |                               | 4. DATE OF DEATH <u>Sept 18 1961</u>  |                                  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>11-28-39</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>  |                               | 9. AGE (in years last birthday) <u>21</u> yrs.  |                                  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                               | 11. BIRTHPLACE (State or foreign country) <u>France</u>   |                                  |
| 13. FATHER'S NAME <u>Michel Multrier</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Genevieve Chirolles</u>   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 17. INFORMANT <u>French Embassy, Washington, D.C.</u>   |                                  |
| 16. SOCIAL SECURITY NO. <u>578-54-6643</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>France</u>  |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                               |   |                                  |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Asphyxia</u>  |                               |   |                                  |
| DUE TO (b) <u>Carbon monoxide poisoning</u>   |                               |   |                                  |
| DUE TO (c) <u>Found dead in auto with hose attached to exhaust</u>  |                               |   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |                                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work  |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |                                  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |                                  |
| ACTUAL SIGNATURE <u>Frank J. Blaszczak</u>  |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                  |
| EXAMINER'S NAME (Type) <u>FRANK J. Blaszczak</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Trans</u>  |                               | 22b. DATE THEREOF   |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rouen Cemetery</u>  |                               | 22d. LOCATION (City, town, or country, [State]) <u>Rouen Seine Martine, France</u>  |                                  |
| 23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>  |                               | 24a. REC'D BY REGISTRAR <u>SEP 27 '61</u>   |                                  |
| ADDRESS <u>Bethesda, Md.</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hester</u>  |                                  |





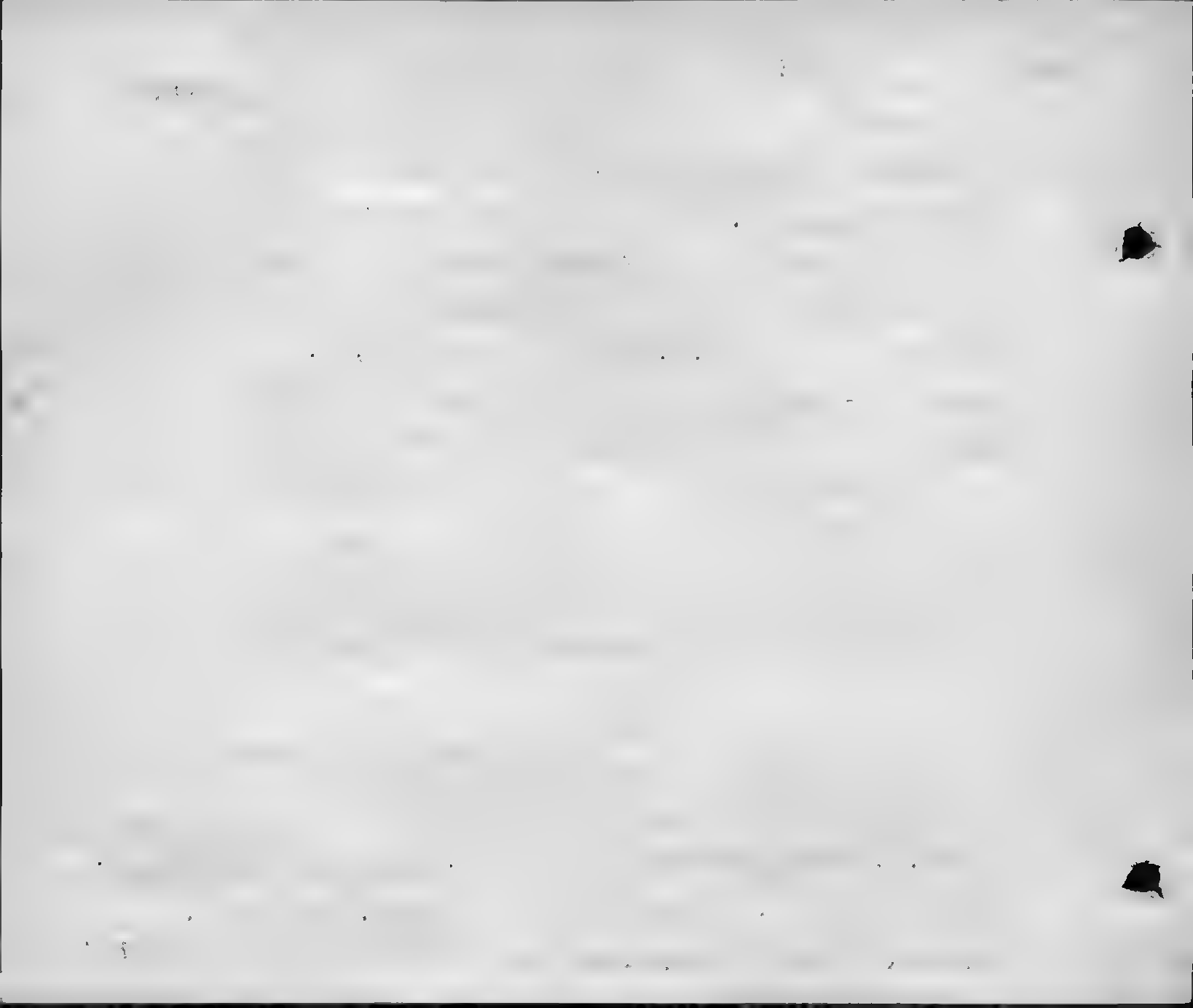




TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

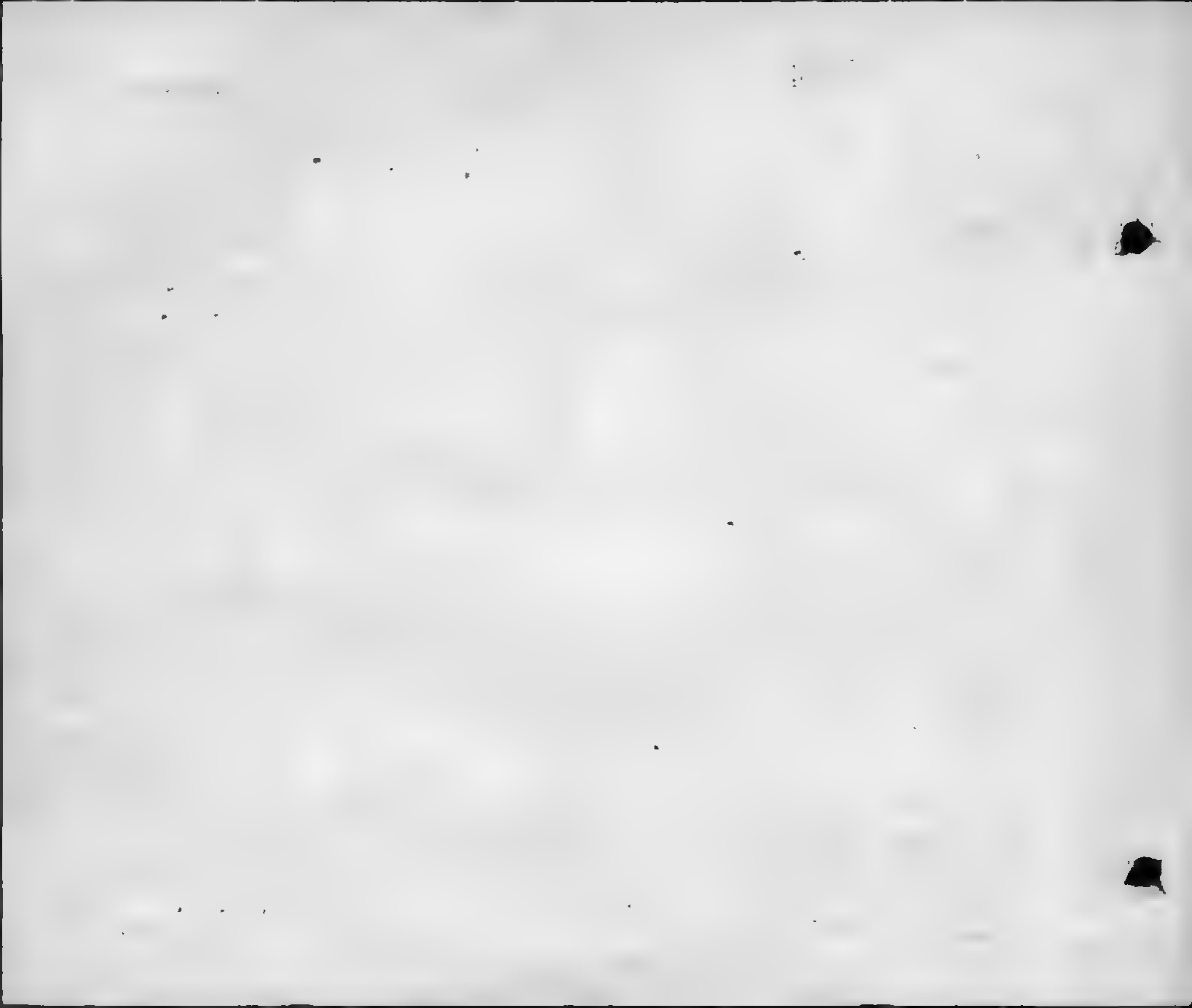
| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |
|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |
| 10423 CERTIFICATE OF DEATH   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b><br>c. LENGTH OF STAY IN 1b <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USNH NMMC BETHESDA, MD.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>a. STATE <b>VIRGINIA</b> b. COUNTY <b>10417</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b><br>d. STREET ADDRESS <b>RT 5 Windsor Estates</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>Abner Franklin NELSON</b>   |  | 4. DATE OF DEATH <b>SEPTEMBER 3 1961</b>  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>Caucasian</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>January 1, 1889</b>   |  |
| 9. AGE (in years, last birthday) <b>72 yrs.</b>  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. NAVY</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>KANSAS CITY, MO.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Frederick -N- NELSON</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Agusta -N- SWENSTON</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>   |  | 16. SOCIAL SECURITY NO <b>577 16 8822</b>   |  |
| 17. INFORMANT <b>Helen NELSON Same as #2</b>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422 Cardio-respiratory cessation</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>acute congestive heart failure</b><br>DUE TO<br>(c) <b>aortic valve stenosis &amp; insuff.</b>         |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b><br><b>years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g.) <b>Atrial fibrillation &amp; R. femoral artery embolic occlusion</b>  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 2, 1961</b> to <b>SEPTEMBER 3, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 3, 1961</b> , and that death occurred at <b>2020 PM</b> , from the causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE <b>Jos. H. Eusterman</b>  |  | 22b. DATE SIGNED <b>SEPTEMBER 3, 1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>JOS. H. EUSTERMAN LT MC USN</b>  |  | 22d. ADDRESS <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>7 SEPT. 1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY, ARLINGTON, VA.</b>  |  | 23d. LOCATION (City, town or county) (State)  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Hall</b>   |  | 25a. REC'D BY REGISTRAR <b>SEP 8 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|--|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Montgomery</i>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Lafayette Park</i>            |  | c. LENGTH OF STAY IN b<br><i>5 days</i>  |  | 2. USUAL RESIDENCE (Where deceased lived, if different from residence before admission)<br>a. STATE<br><i>MD</i>  |  | b. COUNTY<br><i>DC</i>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Washington</i> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Charles Edward Nelson</i>  |  | 4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Wash. San. Hosp.</i>              |  | 5. SEX<br><i>Male</i>  |  | 6. COLOR OR RACE<br><i>White</i>  |  | 7. MARIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> D. VORCED |  | 8. DATE OF BIRTH<br><i>5-1-94</i>   |  |
| 9. AGE (In years, last birthday)<br><i>26</i>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Architect</i>       |  | 11. BIRTHPLACE (County & State or foreign country)<br><i>Sweden</i>                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 13. FATHER'S NAME<br><i>Carl Nelson</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Eugenia Svensson Sweden</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><i>Anna Sheffield 8011 Glenwood Dr</i>                              |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary embolus</i><br>4' DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <i>Diast. thrombosis</i><br>(c), stating the underlying cause last, DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <i>Coronary thrombosis</i> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>12 hours</i>   |  |
| 20a. TIME OF INJURY<br>Hour <i>a.m.</i><br>p.m. <i>19</i>   |  | 20b. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>Nil</i> |  | 20d. (City or town)<br><i>Valhalla, N. Y.</i>   |  | 20e. (County)<br><i>Westchester</i>  |  | 20f. (State)<br><i>N.Y.</i>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>9-2-1961</i> to <i>9-7-1961</i> , that (I) (we) last saw the deceased alive on <i>9-7-1961</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above. |  |  |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><i>Arthur Huse</i>  |  | 22b. PHYSICIAN'S NAME (Type)<br><i>ARTHUR HUSE</i>   |  | 22c. ADDRESS<br><i>1102 Oak Dr. Silver Spring, Md.</i>                               |  | 22d. DATE<br><i>9-7-61</i>  |  | 22e. MED. DIRECTOR<br><input type="checkbox"/>   |  | 22f. STAFF PHYS.<br><input type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>   |  | 23b. DATE THEREOF<br><i>9-9-1961</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Kensico Cemetery</i>                        |  | 23d. LOCATION (City, town or county)<br><i>Valhalla, N. Y.</i>  |  | 23e. REC'D BY REGISTRAR<br><i>SEP 11 '61</i>   |  | 23f. REGISTRAR'S SIGNATURE<br><i>Arthur S. Huse</i>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

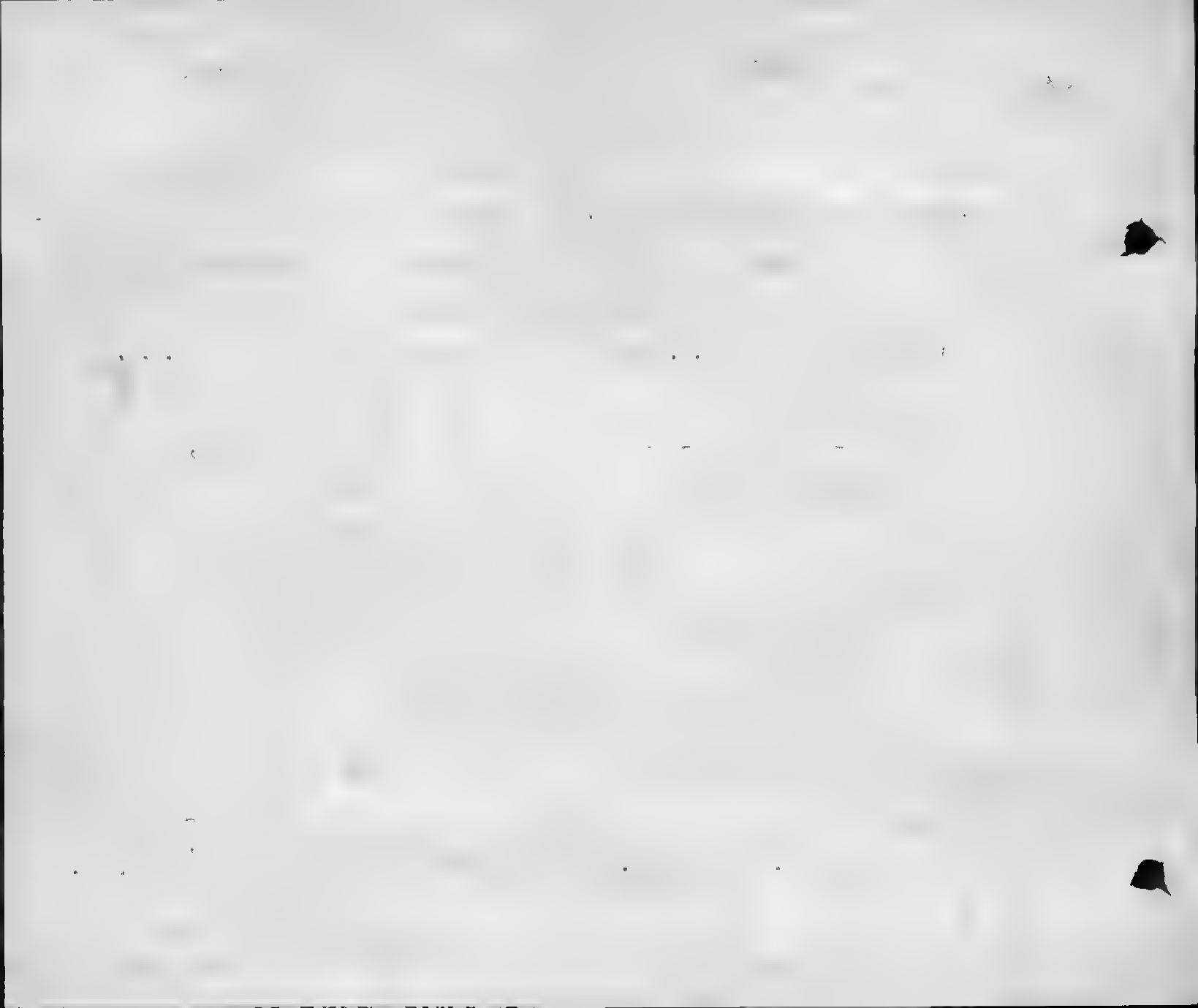
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10425

## CERTIFICATE OF DEATH

10419

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Montgomery   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Michigan |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda  |  | b. COUNTY<br>Detroit   |  |
| c. LENGTH OF STAY IN b.<br>140 days   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>15277 Liberal Avenue             |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.   |  | d. STREET ADDRESS<br>15277 Liberal Avenue  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>Roland Emil Nitchie  |  | <b>4. DATE OF DEATH</b><br>September 5 1961  |  |
| <b>5. SEX</b><br>Male   |  | <b>6. COLOR OR RACE</b><br>White   |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br>February 7, 1919  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Military  |  | <b>9. AGE</b> (In years, IF UNDER 1 YEAR, last birthday) IF UNDER 24 HRS. Months Days Hours Min.<br>42 yrs           |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>U.S. Army   |  | <b>11. BIRTHPLACE</b> County & State or foreign country<br>Montana   |  |
| <b>13. FATHER'S NAME</b><br>Emil Nitchie  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br>Lillian Doubt  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)<br>Yes 1948 - 1960                          |  |
| <b>16. SOCIAL SECURITY NO.</b><br>517-14-0870   |  | <b>17. INFORMANT</b><br>The Medical Record   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular accident<br>42-2-1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular disease<br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psoriatic Arthritis |  | <b>19. INTERVAL BETWEEN ONSET AND DEATH</b><br>2 Days<br>Years   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)                    |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. 19  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>        |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from April 18 1961 to September 5 1961, that (I) (we) last saw the deceased alive on September 5 1961, and that death occurred at 4:45 AM from the causes and on the date stated above.</b>   |  |  |  |
| <b>22a. SIGNATURE</b><br>David V. Kimberg   |  | <b>22b. DATE SIGNED</b><br>9-5-61  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br>David V. Kimberg M.D.  |  | <b>22d. ADDRESS</b><br>The Clinical Center, National Institutes of Health, Bethesda 14, Md.                          |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>BURIAL  |  | <b>23b. DATE THEREOF</b><br>9 SEPT. 1961   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>KINALDI FUNERAL HOME INC. 816 H ST. N.E. DC 2  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br>DETROIT MICH.   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b>   |  | <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b><br>SEP 7 '61 Arthur S. Kraus                        |  |



1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10426

10420

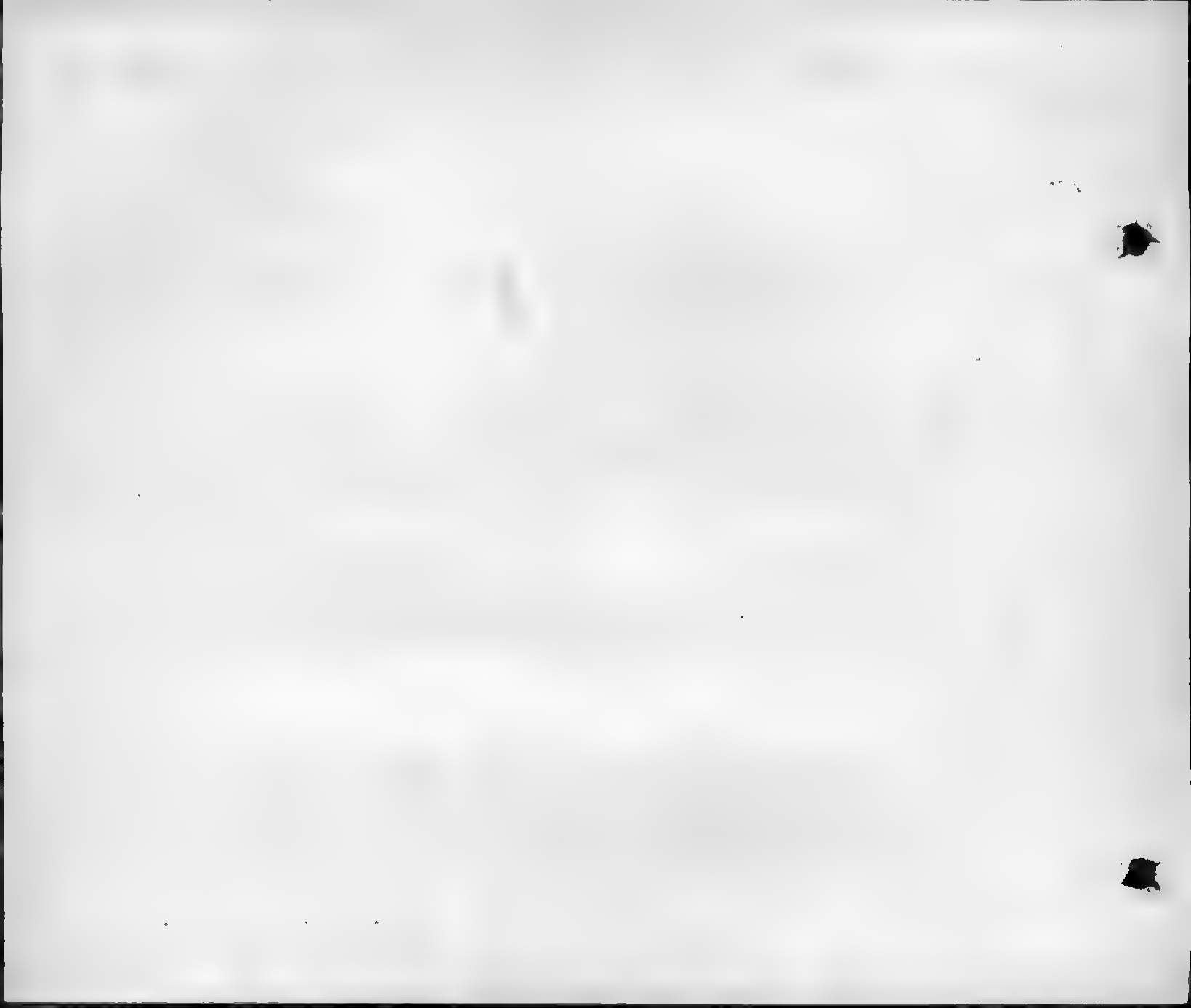
|  |                           |   |   |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iukoma Park</u><br>c. LENGTH OF STAY IN b. <u>D.O.A.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>   |                           | 2. USUAL RESIDENCE (Where deceased lived, if in hospital, give address before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>4306 Ferrara Drive</u> |   |
| 3. NAME OF DECEASED (Type or print) <u>Jean Christine Nitowitz</u>   |                           | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>26</u> Year <u>1961</u>   |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>7-8-27</u>                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>   | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> |
| 13. FATHER'S NAME <u>Herman Moran</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>  |                           | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>  |   |
| 17. INFORMANT <u>Harold Nitowitz</u>   |                           | Address <u>Silver Spring, Md. 4306 Ferrara Dr.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEMORRHAGE, MASSIVE</u><br>DUE TO <u>MULTIPLE LACERATIONS OF LIVER</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>AUTO ACCIDENT</u><br>DUE TO <u>AUTO ACCIDENT</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>"</u><br><u>"</u> |                           |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18) <u>Thorn from car - auto accident</u>   |   |
| 20c. TIME OF INJURY Month, Day, Year <u>9-26-61</u><br>Hour a.m. <u>1:00</u>   |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>                                     |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                           | 22. LOCATION (City, town, or country) (State) <u>Silver Spring Monty md</u>   |   |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>   |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 22b. DATE THEREOF <u>9/28/61</u>   |                           | DATE SIGNED <u>9-26-61</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>NATL MEM PARK</u>  |                           | 22d. LOCATION (City, town, or country) (State) <u>FALLS CHURCH, VA.</u>   |   |
| 22e. FUNERAL DIRECTOR <u>Frederick Howard Hume</u>   |                           | 24a. REC'D BY REGISTRAR <u>27 '61</u>   |   |
| ADDRESS <u>4217-9th St NW</u>  |                           | 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>  |   |





1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
10427 CERTIFICATE OF DEATH 10421

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>                         |  |  |  |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> H 7 X - 3   |  |  |  |
| c. LENGTH OF STAY IN 1b <u>35 days</u>  |  |  |  | d. STREET ADDRESS <u>1423 Frying St. N.W. Box 5106</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium and Hospital</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>THEODORE</u>   |  | First  |  | Middle <u>TEMPLETON</u>  |  | Last <u>OFFTERDINGER</u>   |  |
| 5 SEX <u>M</u>  |  | 6 COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>4-26-93</u>  |  |
| 9. AGE (In years last birthday) <u>68</u> yrs   |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS Hours Min  |  | DATE OF DEATH <u>Sept. 19 1961</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>HENRY OFFTERDINGER</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>ALICE TEMPLETON</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>577-24-7609</u>   |  | 17. INFORMANT <u>Hospital chart</u> Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4-20-60</u> DUE TO <u>Congestive Heart Failure</u>   |  |  |  |  |  | <u>4 days</u>  |  |
| Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <u>Arteriosclerotic Heart Disease</u>   |  |  |  |  |  | <u>? years</u>   |  |
| DUE TO (c) <u>Coronary Infarction</u>   |  |  |  |  |  | <u>? years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Kidney</u>  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1961</u> to <u>Sept 19 1961</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Sept 19 1961</u> , and that death occurred at <u>7:25 P</u> , from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Robert A. Hare</u> M.D.   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <u>9/19/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare, MD.</u>   |  |  |  | 22d. ADDRESS <u>7600 Carroll Ave. T.P. Md</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>   |  | 23b. DATE THEREOF <u>9/22/61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>  |  | 23d. LOCATION (City, town, or county) (State)  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. Thomas Co</u> ADDRESS <u>2901 14th St. N.W.</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>SEP 21 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Christine S. Thomas</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>M</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rismore San. &amp; Hospital</u>  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>WASH.</u> b. COUNTY <u>D.C.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 x -3</u><br>d. STREET ADDRESS <u>4000 Cathedral Ave NW</u> |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>SARAH</u> <u>CAFRITZ</u> <u>ORNSTEIN</u>   |  |  |  |  |  | 4. DATE OF DEATH <u>9</u> / <u>28</u> / <u>61</u><br>Month Day Year  |  |  |  |  |  |  |  |
| 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  | 8. DATE OF BIRTH <u>JAN 1, 1888</u><br>9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>  |  |  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>                              |  |
| 13. FATHER'S NAME <u>NATHAN CAFRITZ</u>  |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>ANNA (unknown) Freed</u>   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)   |  |  |  |  |  | 16. SOCIAL SECURITY NO. <u>DR, EDW. A. CAFRITZ</u>   |  |  |  |  |  | 17. INFORMANT Address <u>4000 PATH. AVE NW</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA.</u><br>4-2-1<br>Conditions, if any, which gave rise to immediate cause (b) <u>MYOCARDIAL FAILURE</u><br>(c) <u>ARTERIOSCLEROTIC CARDIOVASC. DISEASE</u><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>NONE.</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>NONE.</u>   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>9/28/61</u>  |  |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5237</u> |  | 20f. (City or town) (County) (State)                           |  |  |  |
| 21. I certify that (I) (th.s hospital) attended the deceased from <u>MAY 11</u> , 19 <u>61</u> , to <u>SEPT 18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/28/61</u> , 19 <u>61</u> , and that death occurred at <u>5237</u> from the causes and on the date stated above.  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Maxwell Hurston M.D.</u>   |  |  |  |  |  | 22b. DATE SIGNED <u>9/28/61</u>  |  |  |  |  |  | 22c. PHYSICIAN'S NAME (Type) <u>DR. MAXWELL HURSTON</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  |  |  |  | 23b. DATE THEREOF <u>10/1/61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Hebrew Cem.</u>                        |  | 23d. LOCATION (City, town or county) (State) <u>Wash. D.C.</u> |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kanyansky</u>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>3501-14 St. NW</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>                                  |  | DATE <u>OCT 3 '61</u>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

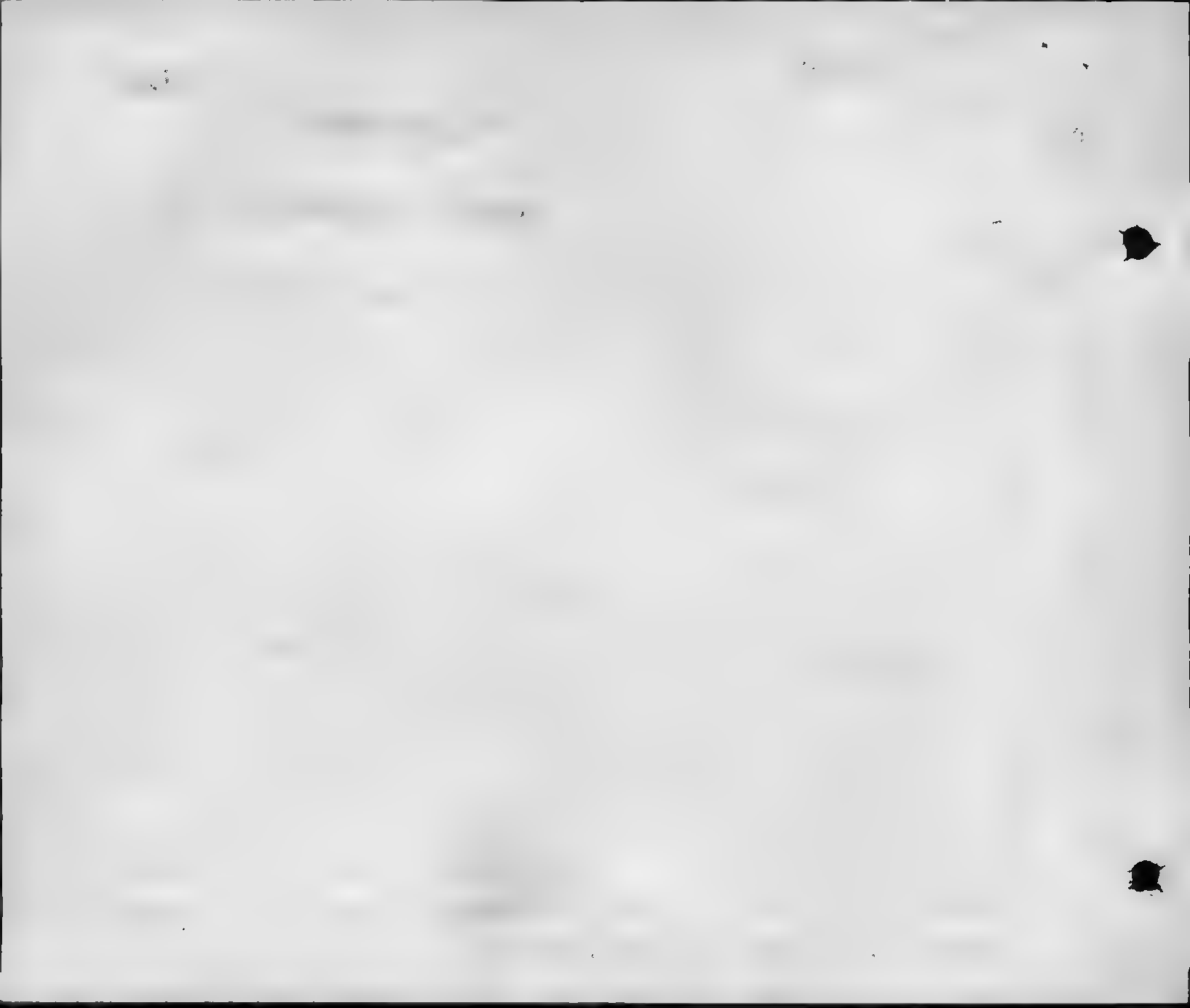
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10429

## CERTIFICATE OF DEATH

10423

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> |  | <b>2. USUAL RESIDENCE</b> [Where deceased lived, if institution; Residence before admission]<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>d. STREET ADDRESS <u>919 Grandin Avenue</u> |  | <b>3. NAME OF DECEASED</b><br>(Type or print) <u>MARY Helen Osmond</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>9</u> Day <u>19</u> Year <u>1961</u>  |  |  |  |  |  |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>W</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>9-21-1899</u> |  | <b>9. AGE</b> (In years last birthday) <u>61</u> yrs.   |  | <b>10. IF UNDER 1 YEAR</b><br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |  | <b>11. IF UNDER 24 HRS.</b><br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>                |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Derwood, Montgomery, Md.</u>                                    |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  | <b>13. FATHER'S NAME</b><br><u>John Oliver Crown</u>                                     |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>MARY M. M. M.</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>4-21-1899</u>   |  | <b>17. INFORMANT</b> <u>Frank J. Osmond</u>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per 10a for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerosis</u><br>DUE TO<br>(c) <u>Coronary Artery Disease</u> |  | <b>19. INTERVAL BETWEEN ONSET AND DEATH</b><br><u>25 YEARS</u><br><u>15 YEARS</u>        |  | <b>20. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)   |  | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)            |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JAN</u> , 19 <u>55</u> to <u>SEPT 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>5 SEPT 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.                           |  | <b>22a. SIGNATURE</b><br><u>Arthur S. Pumphrey</u>  |  | <b>22b. DATE SIGNED</b><br><u>20 SEPT 1961</u>  |  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Robert A. Pumphrey</u>  |  | <b>22d. ADDRESS</b><br><u>3010 W. MONTGOMERY BLVD</u><br><u>ROCKVILLE, MARYLAND</u>      |  | <b>22e. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Pumphrey</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>9/22/61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Rockville Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Rockville, Maryland</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 21 '61</u>                                      |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Pumphrey</u>   |  |



may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

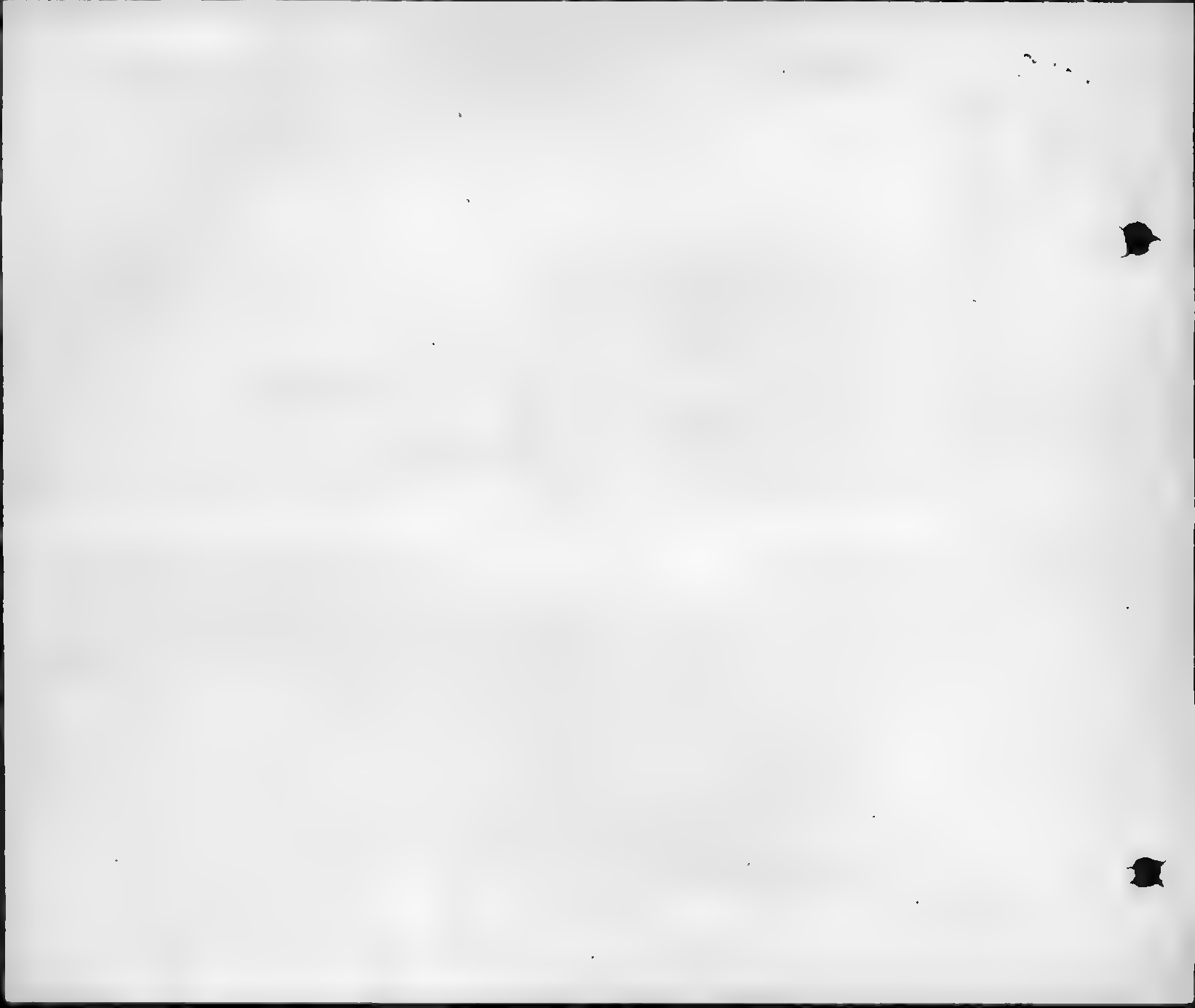
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

10430

10424

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                     | c. LENGTH OF STAY IN 1b<br><u>5 yrs.</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Congressional Manor Soc.</u>   |                                     | e. STREET ADDRESS<br><u>805 Reading Ave.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JAMES</u> Middle <u>R.</u> Last <u>PARSLEY</u>  |                                     | f. DATE OF DEATH<br>Month <u>9</u> Day <u>14</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10/25/1888</u>   |
| 9. AGE (In years last birthday)<br><u>72</u> yrs.   |                                     | 10. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min <u>1</u>   | 11. IF UNDER 24 HRS<br>Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Lumber Checker</u>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Ret-</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>William O. Parsley</u>  |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Christina Mullican</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                     | 16. SOCIAL SECURITY NO<br><u>Yes Unknown</u>  |   |
| 17. INFORMANT<br><u>Elsie May Parsley-wife-same 2d</u>  |                                     | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral Infarction</u><br>Conditions, if any which gave rise to immediate cause (c), stating the underlying cause last (b) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Thrombosis</u><br>(c) <u>Cerebral Intermedullary</u> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u><br><u>1 month</u><br><u>2 weeks</u>  |   |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Usual. Medication</u>   |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/1/1961</u> to <u>9/14/1961</u> that (I) (we) last saw the deceased alive on <u>9/14/1961</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.   |                                     |   |   |
| 22a. SIGNATURE<br><u>Stephen N. Jones</u>   |                                     | 22b. DATE SIGNED<br><u>9/14/61</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Stephen N. Jones</u>   |                                     | 22d. ADDRESS<br><u>809 Viers Mill Rd. Rock. Md.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>9/16/61</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rockville Cemetery</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>Rockville, Maryland</u>       |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey, Bethesda, Maryland</u>   |                                     | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 18 '61</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hume</u>   |                                     |   |   |





# MARYLAND STATE DEPARTMENT OF HEALTH

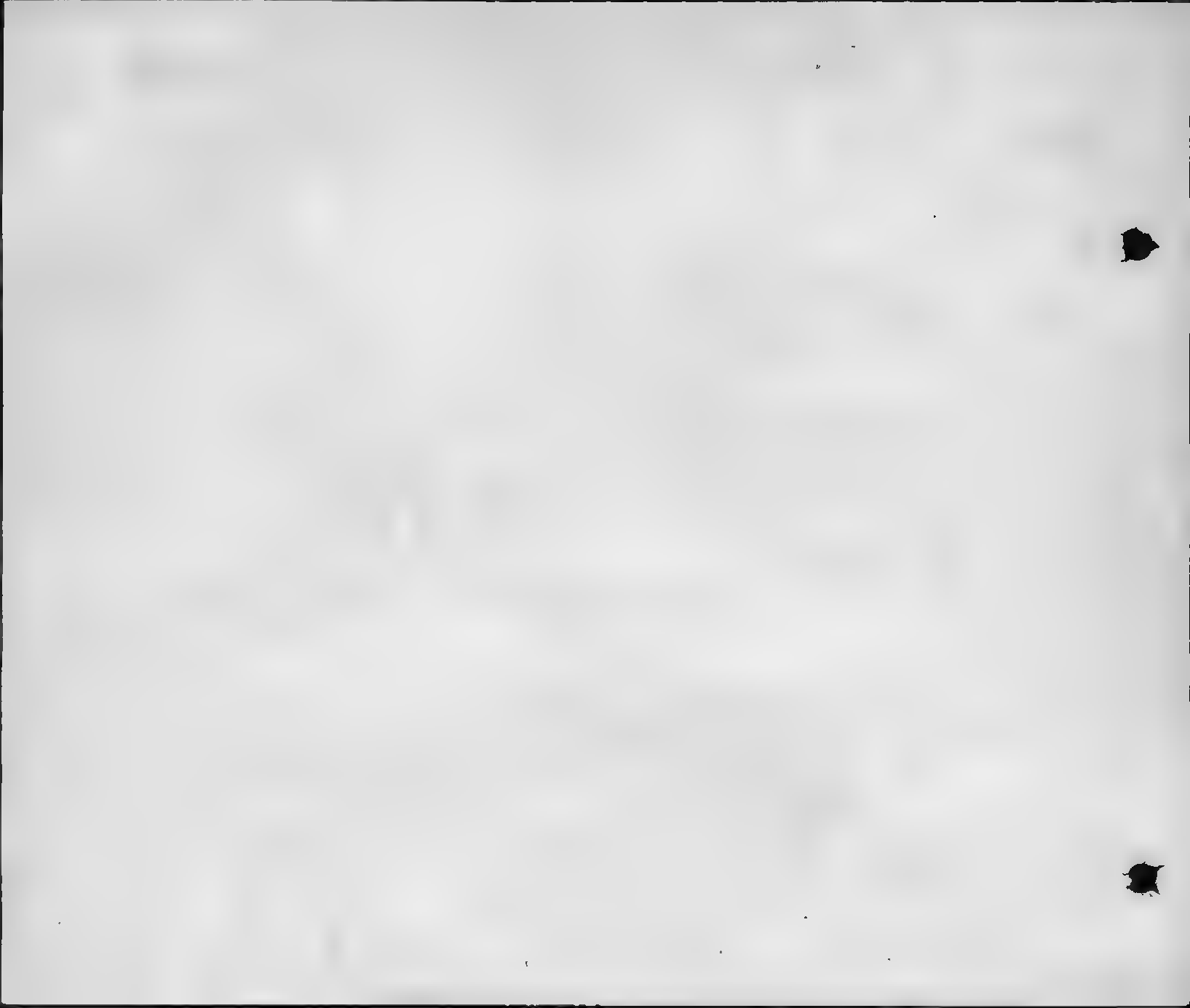
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10425

**1**  
**FOR STATE HEALTH DEPT.**

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>c. LENGTH OF STAY IN 1b <u>2 hrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Snyder's Super Market</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if first lot or residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>mnty</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>12004 Colin Rd</u> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Warren Wilford Payne</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>Sept</u> Day <u>4</u> Year <u>1961</u>                                       |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>5. SEX</b> <u>male</u>  |  | <b>6. COLOR OR RACE</b> <u>white</u>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |
| <b>8a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Butcher</u>   |  | <b>8b. KIND OF BUSINESS OR INDUSTRY</b> <u>Snyder's Super Market</u>   |  | <b>9. AGE</b> (In years, last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>1</u> IF UNDER 24 HRS: Hours <u>1</u> Min. <u>35</u>   |  |  |  |
| <b>10a. FATHER'S NAME</b> <u>Carol Payne</u>   |  | <b>10b. MOTHER'S MAIDEN NAME</b> <u>Unknown Taylor</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Us</u>   |  |  |  |
| <b>12. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>   |  | <b>13. SOCIAL SECURITY NO.</b> <u>unable to locate</u>   |  | <b>14. INFORMANT</b> <u>Pearl Payne (wife)</u> Address <u>Stun 2</u>   |  |  |  |
| <b>15. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u><br>(b) <u>Occclusion Arterio Coronary Artery</u><br>(c) <u>Rupture with hemorrhage of thoracic Aorta</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Sudden</u>       |  |  |  |  |  |  |  |
| <b>16a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | <b>16b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| <b>17a. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>9</u> a.m. <u>19</u> p.m.   |  | <b>17b. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>17c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| <b>17d. (City or town)</b>   |  | <b>17e. (County)</b>   |  | <b>17f. (State)</b>  |  |  |  |
| <b>18. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> M.D.   |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |  | <b>DATE SIGNED</b>   |  |  |  |
| <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>  |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |  | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>   |  | <b>22b. DATE THEREOF</b> <u>SEPT. 7, 1961</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PORT LINCOLN CEMETERY</u>   |  |  |  |
| <b>22d. LOCATION (City, town, or country)</b> <u>PRINCE GEORGE'S CEMETERY, MD.</u>   |  | <b>22e. REC'D BY REGISTRAR</b>   |  | <b>22f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>   |  |  |  |
| <b>23. FUNERAL DIRECTOR</b> <u>Raymond A. Ziska</u>  |  | <b>23a. ADDRESS</b> <u>WALTER D. PUMPHREY, INC., SILVER SPRING, MD.</u>  |  | <b>23b. DATE</b> <u>SEP 6 '61</u>  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

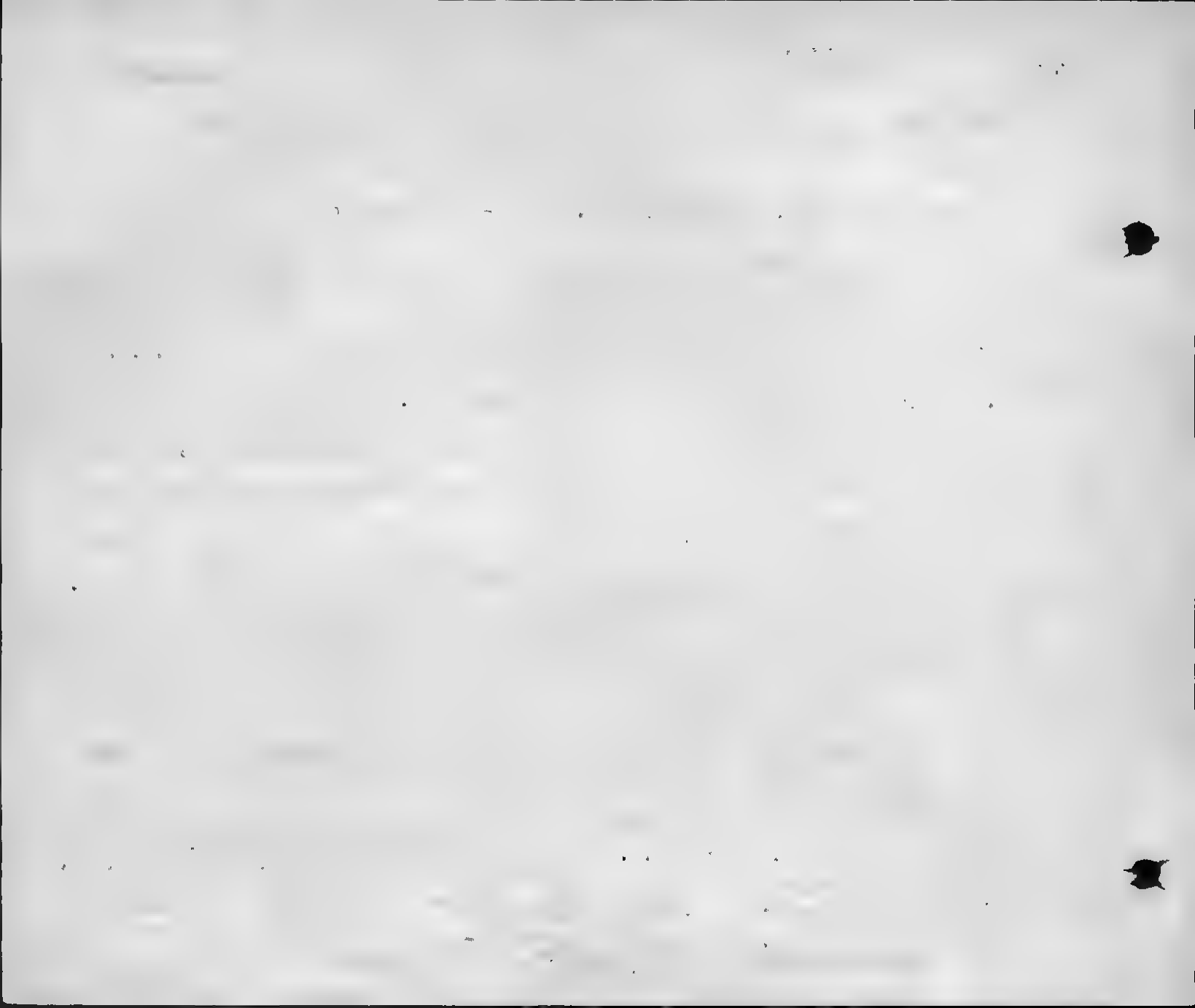
10432

## CERTIFICATE OF DEATH

10426

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br><u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br>c. LENGTH OF STAY IN 1b<br><u>5 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda 14, Md.</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Prince Georges</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Greenbelt</u><br>d. STREET ADDRESS<br><u>56-H Crescent Road</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First Middle Last<br><u>Bonnie Elaine Pehl</u>  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>September 3 1961</u>   |  |
| <b>5. SEX</b><br><u>Female</u><br><b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b><br><u>May 13, 1955</u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Child</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>None</u>  |  | <b>11. BIRTHPLACE</b> (County & State or foreign country)<br><u>Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>M. Milburn Pehl</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Dorothy C. Caswell</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No</u>   |  | <b>16. SOCIAL SECURITY NO</b><br><u>None</u><br><b>17. INFORMANT</b> <u>The Medical Record</u><br><u>The Clinical Center, Bethesda 14, Maryland</u>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gram negative septicemia; gastrointestinal hemorrhage</u><br>(b) <u>Acute pyelonephritis</u><br>(c) <u>Acute lymphatic leukemia</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)<br><u>August 29, 1961 to September 3, 1961</u><br><u>5:50 PM</u> |  |  |  |
| <b>21. I certify that</b> (this hospital) attended the deceased from <u>August 29, 1961</u> to <u>September 3, 1961</u> that (we) last saw the deceased alive on <u>September 3, 1961</u> , and that death occurred at <u>5:50 PM</u> from the causes and on the date stated above.  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Robert H. Levin M.D.</u><br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert H. Levin M.D.</u>  |  | <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/><br><b>22d. ADDRESS</b><br><u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>   |  |
| <b>23a. FUNERAL, CREMATION, 23b. DATE THEREOF</b><br><u>Burial 9/6/61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Washington Nat.</u><br><b>23d. LOCATION</b> (City, town or county) (State)<br><u>Suitland, Md.</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Lee Funeral Home</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b><br><u>SEP 8 '61</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



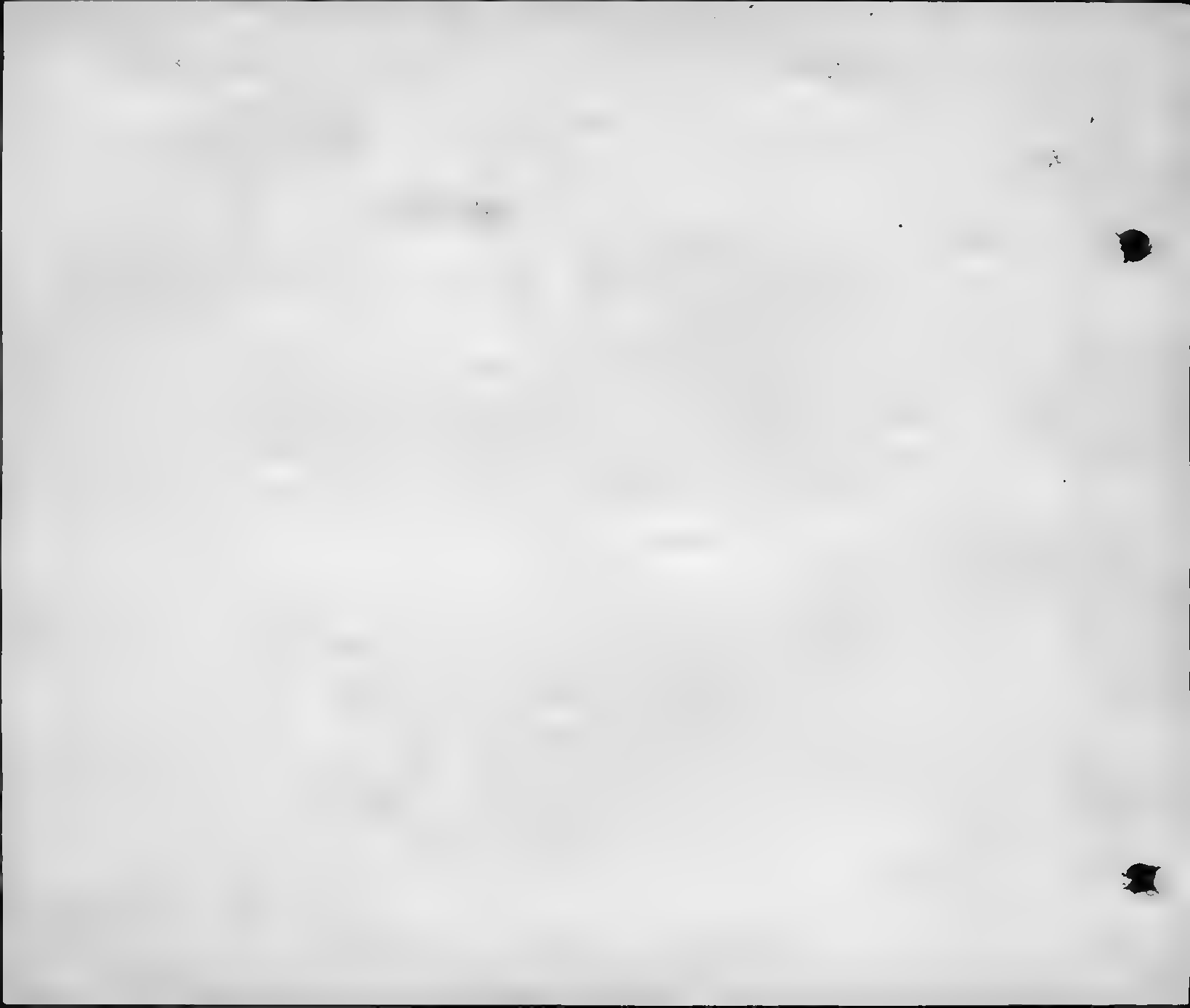
1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 1 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |  |   |  |  |   |  |  |
| 10433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10427   |  |  |   |  |  |   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>                                   |  |  | c. LENGTH OF STAY IN 1b <u>29 days 16 hours</u>   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>  |  |  | e. STREET ADDRESS <u>8073 Georgia Avenue</u>  |  |  | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  | g. DATE OF DEATH <u>September 23 1961</u>   |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Alvah</u>  |  |  | 4. DATE OF DEATH <u>September 23 1961</u>   |  |  | 5. SEX <u>male</u>  |  |  | 6. COLOR OR RACE <u>white</u>   |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>   |  |  | 8. DATE OF BIRTH <u>August 12, 1904</u>   |  |  | 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>57 yrs.</u>                                   |  |  | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>   |  |  | 12. KIND OF BUSINESS OR INDUSTRY <u>Kitchen helper</u>  |  |  | 13. BIRTHPLACE (State or foreign country) <u>Maryland-Balto.</u>  |  |  | 14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |
| 15. FATHER'S NAME <u>William E. Peters</u>  |  |  | 16. MOTHER'S MAIDEN NAME <u>Sarah C. Englar</u>   |  |  | 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> |  |  | 18. SOCIAL SECURITY NO. <u>10433</u>  |  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  | 20. IMMEDIATE CAUSE (a) <u>SEVERE HEPATIC COMA</u>  |  |  | 21. DUE TO (b) <u>TERMINAL SEVERE PORTAL CIRRHOSIS</u>  |  |  | 22. DUE TO (c) <u>ACUTE PURULENT CYSTITIS</u>   |  |  |
| 23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART IIa   |  |  | 24. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 25. INTERVAL BETWEEN ONSET AND DEATH <u>days</u>  |  |  | 26. months  |  |  |
| 27. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  | 28. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell on kitchen floor while at work</u> |  |  | 29. TIME OF INJURY Month, Day, Year <u>8-25 1961</u>  |  |  | 30. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Restaurant</u>                           |  |  |
| 31. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | 32. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 33. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 34. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |
| 35. ACTUAL SIGNATURE <u>Frank J. Broschek</u>   |  |  | 36. EXAMINER'S NAME (Type) <u>FRANK J. Broschek</u>   |  |  | 37. DATE SIGNED <u>9-24-61</u>  |  |  | 38. ADDRESS (Street, city, town, or county) <u>Baltimore, Md.</u>   |  |  |
| 39. 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  | 40. 22b. DATE THEREOF <u>9-27-61</u>  |  |  | 41. 22c. NAME OF CEMETERY OR CREMATORY <u>Takoma Park</u>   |  |  | 42. 22d. LOCATION (City, town, or country) (State) <u>Balto. Maryland</u>   |  |  |
| 43. 23. FUNERAL DIRECTOR <u>Wm J. Jackson</u>   |  |  | 44. ADDRESS <u>Baltimore 17, Md.</u>  |  |  | 45. 24a. REC'D BY REGISTRAR <u>SEP 25 '61</u>   |  |  | 46. 24b. REGISTRAR'S SIGNATURE <u>William E. Peters</u>   |  |  |



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# MARYLAND STATE DEPARTMENT OF HEALTH

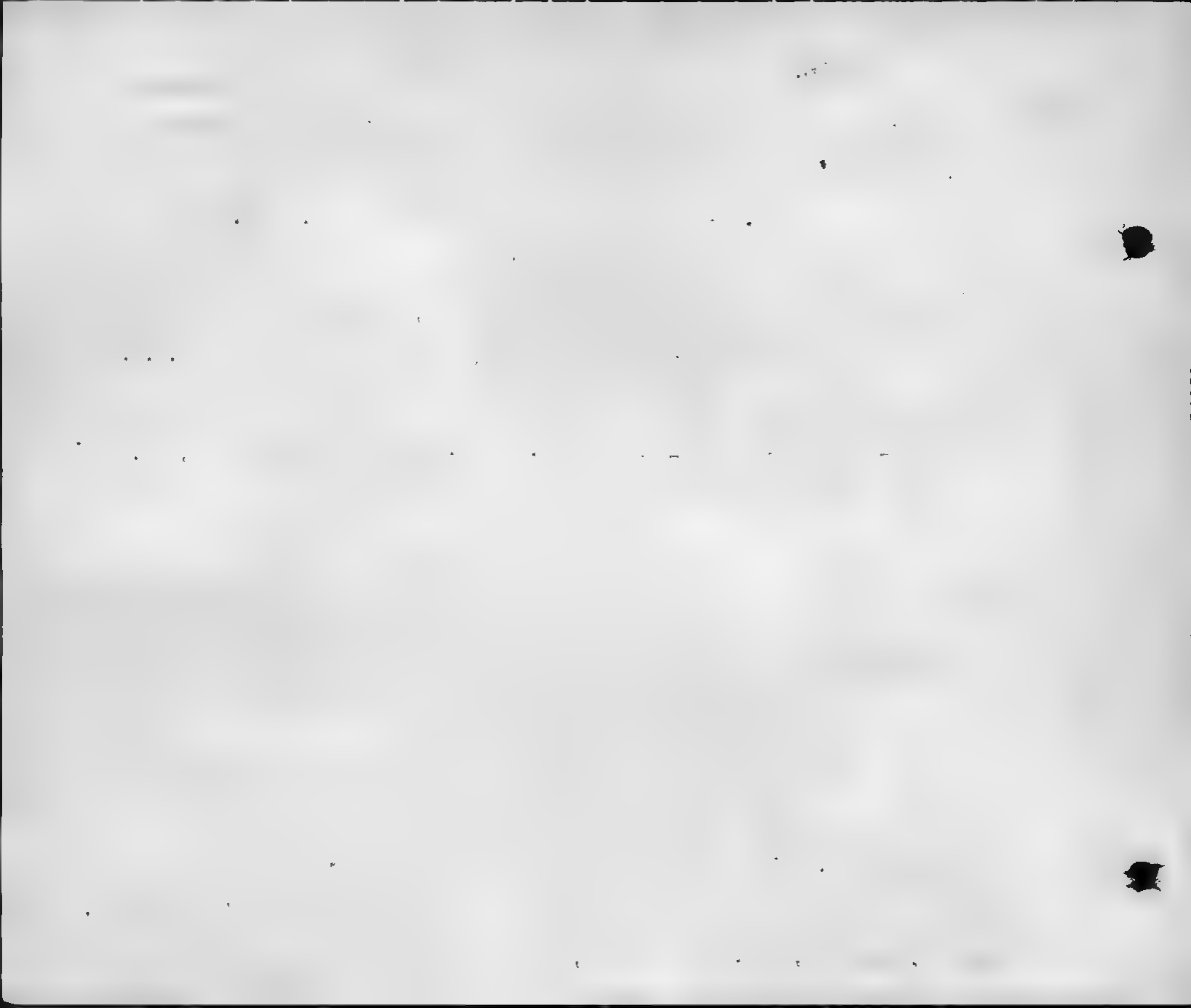
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10434

10428

|   |                               |   |  |
|---|-------------------------------|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>c. LENGTH OF STAY IN b. <u>Four years</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8019 Eastern Ave. Apt. T-2</u> |                               | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, give address before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>8019 Eastern Ave. Apt. T-2</u><br>e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Allen Richard Philpot Sr</u>   |                               | 4. DATE OF DEATH <u>September 27 1961</u>   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>September 8, 1886</u> 75 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator- Retired Equipment</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Heavy construction</u>   |  |
| 11. BIRTH PLACE (County & State or foreign country) <u>Rome, Georgia</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Joseph Philpot</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Josephine Jenks</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>579-07-1694</u>  |  |
| 17. INFORMANT <u>Mrs. Rex S. Steffey</u>  |                               | Address <u>8011 Eastern Avenue Apt. 106 Silver Spring, Md.</u>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)  |                               |   |  |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE + MYASTHENIA</u>  |                               |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SQUAMOUS CELL CARCINOMA LARYNX</u>  |                               |   |  |
| (c) <u>3 YEARS</u>  |                               |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>INTERVAL BETWEEN ONSET AND DEATH 2 DAYS</u>   |                               |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |                               |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>DEC 1955</u> to <u>SEPT 1961</u> , that (I) (we) last saw the deceased alive on <u>27 SEPT 1961</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.  |                               |   |  |
| 22a. SIGNATURE <u>Henry R. Wolfe</u>  |                               | 22b. DATE SIGNED <u>4/28/61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE</u>  |                               | 22d. ADDRESS <u>905 Sheridan St. Chillum Terrace, Maryland</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>9/29/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>   |                               | 23d. LOCATION (City, town or county) (State) <u>Prince George's County Md.</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>  |                               | 25a. REC'D BY REGISTRAR <u>OCT 2 '61</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>  |                               | 25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

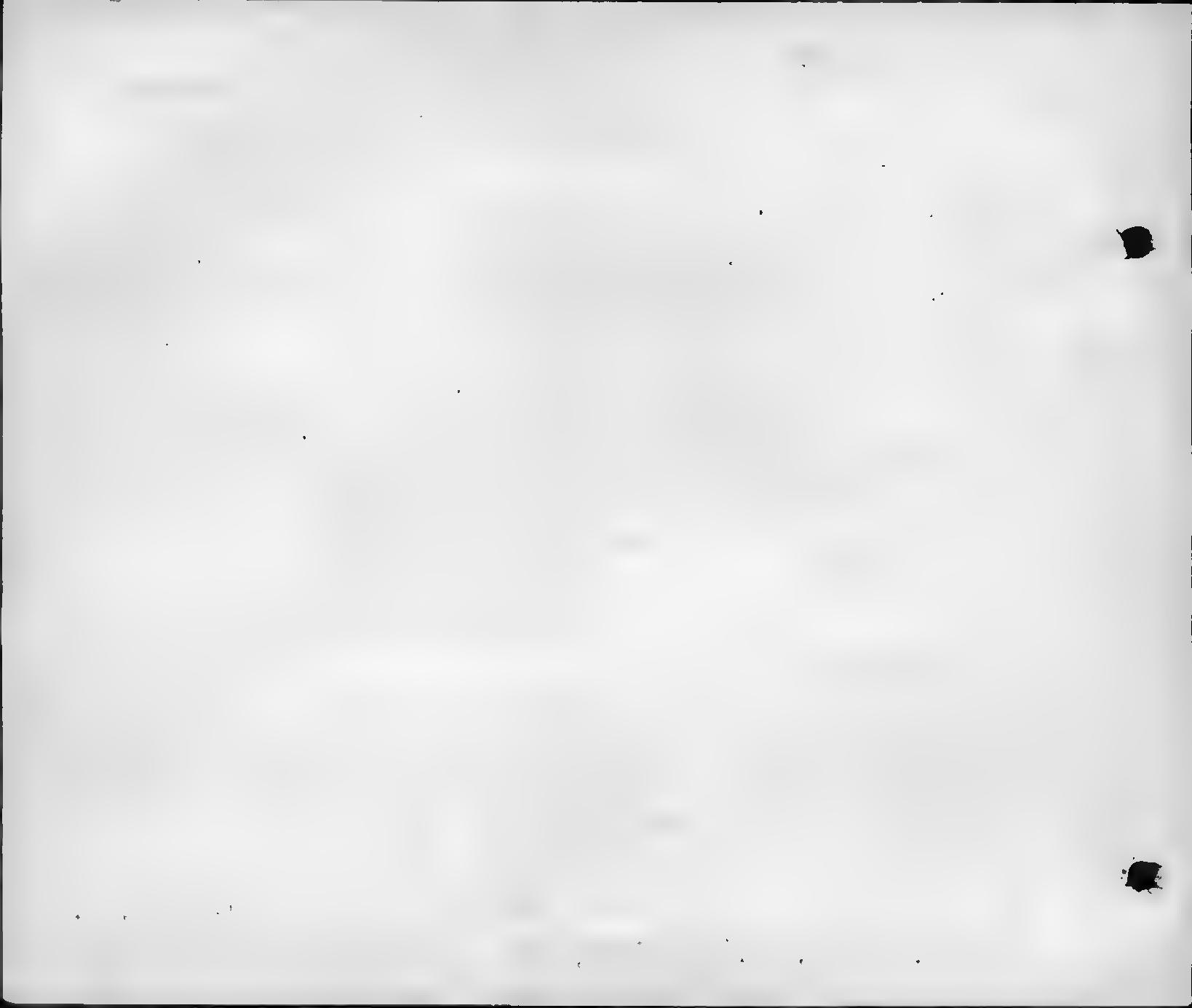
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VR ATS (4)  
15M 9/59

10435

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                          |  |  |  |  |  |  |
|---|--------------------------|--|--|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                          |  |  | 2 USUAL RESIDENCE (Where deceased lived. If institution, state name and date of admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>NORBECK - RURAL</u>  |                          |  |  | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>RURAL - NORBECK</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16015 Emory Lane.</u>   |                          |  |  | d. STREET ADDRESS <u>16015 Emory Lane</u>  |  |  |  |
| 3 NAME OF DECEASED (Type or print) First Middle Last<br><u>ROBERT Reeve PRATT</u>   |                          |  |  | 4. DATE OF DEATH Month Day Year<br><u>Sept. 21 1961</u>  |  |  |  |
| 5 SEX <u>M</u>  | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>MARCH 31, 1919</u> | 9 AGE (In years last birthday) <u>42</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min | IF UNDER 24 HRS<br>Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instrument maker</u>   |                          | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Standards</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>Jesse Garfield Pratt</u>   |                          |  |  | 14. MOTHER'S MAIDEN NAME <u>Reeve, Grace</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>  |                          | 16. SOCIAL SECURITY NO. <u>1945-mm-sept 578-09-8509</u>  |  | 17. INFORMANT <u>wife</u> Address <u>16015 Emory Lane, Norbeck</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HyperTensive Cardiovascular disease</u> DUE TO (c) <u>5 months</u> |                          |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                          |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                          | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                          | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1959</u> to <u>Sept 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 21, 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.   |                          |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Lillian K. Ziegler</u> M.D.   |                          |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Ziegler, Lillian K.</u>   |                          |  |  | 22d. ADDRESS <u>Olney, Md.</u>   |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>   |                          | 23b. DATE THEREOF <u>9/21/61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>               |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Zisk</u> ADDRESS <u>8434 Georgia Avenue</u>  |                          |  |  | 25a. REC'D BY REGISTRAR <u>SEP 25 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>  |  |
| Warner E. Pumphrey, Inc. Silver Spring, Maryland  |                          |  |  |  |  |  |  |



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# MARYLAND STATE DEPARTMENT OF HEALTH

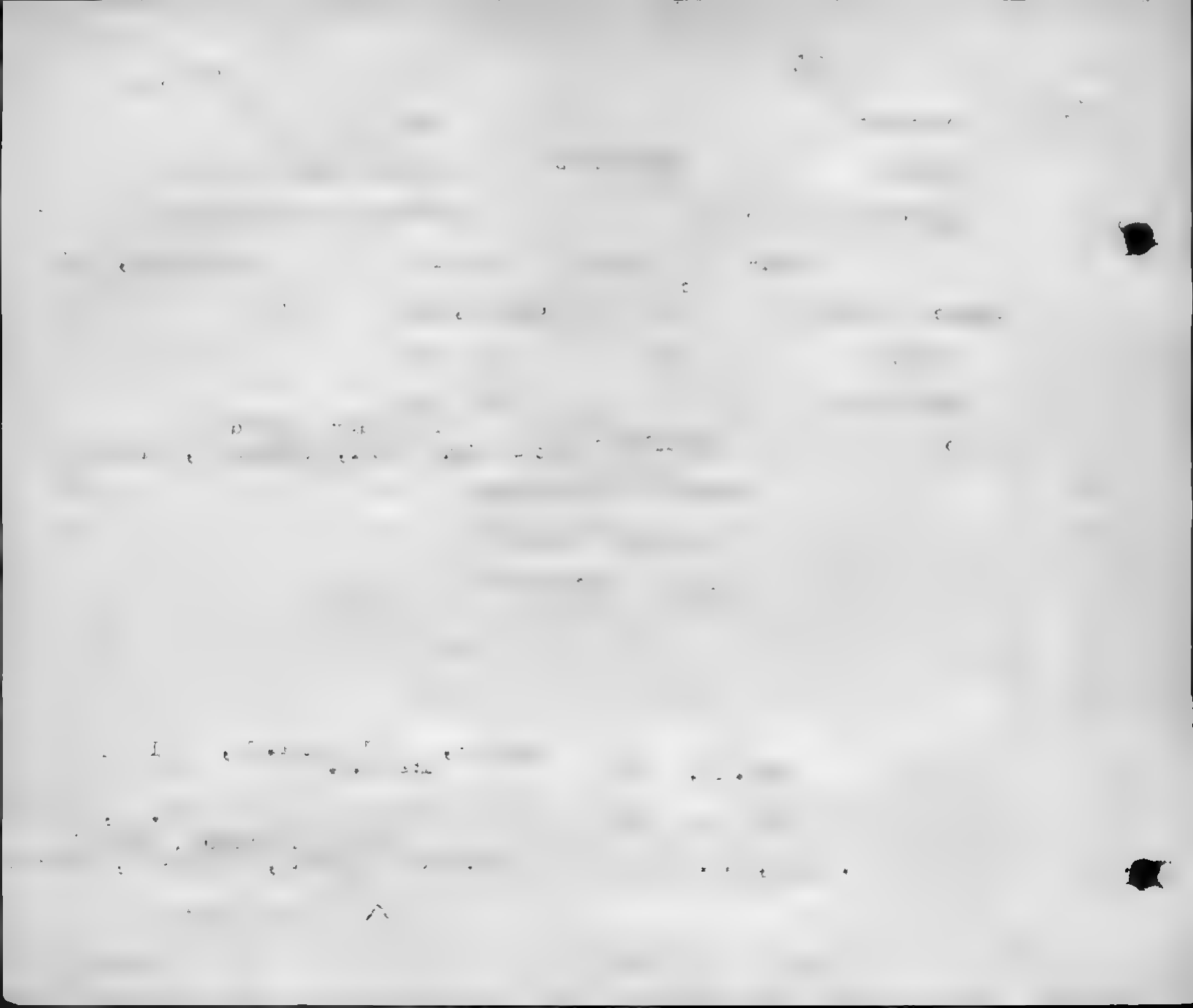
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10436

## CERTIFICATE OF DEATH

10430

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN TOWN <b>45 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>                                       |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if different from residence before admission)<br>a. STATE <b>Idaho</b><br>b. COUNTY <b>Idaho</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mountain Home</b><br>d. STREET ADDRESS <b>869 South 3rd West Street</b>  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><b>KEITH MARIE PRUITT</b>  |  | <b>4. DATE OF DEATH</b><br><b>September 19, 1961</b>  |  |
| <b>5. SEX</b> <b>Female</b><br><b>6. COLOR OR RACE</b> <b>White</b><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <b>June 23, 1940</b><br><b>9. AGE</b> (In years, last birthday) <b>21 yrs.</b><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b><br><b>11. BIRTHPLACE</b> (Country & State or foreign country) <b>Virginia</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b> |  |
| <b>13. FATHER'S NAME</b> <b>Boyd Gilmore</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b> <b>Ida Sargent</b>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>   |  | <b>16. SOCIAL SECURITY NO.</b> <b>Unavailable</b><br><b>17. INFORMANT</b> <b>The Medical Record</b><br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1545</b> <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Atrial Septal Defect</b><br>(c) <b>Congenital Heart Disease</b> |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 Months</b>   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that I (this hospital) attended the deceased from August 5, 1961, to Sept. 19, 1961, that (we) last saw the deceased alive on Sept. 19, 1961, and that death occurred at 1:20 p.m. from the causes and on the date stated above.</b>  |  |   |  |
| <b>22a. SIGNATURE</b><br><b>Dean T. Mason, M.D.</b>  |  | <b>22b. DATE SIGNED</b> <b>Sept. 19, 1961</b>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>Dean T. Mason, M.D.</b>  |  | <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>   |  | <b>23b. DATE THEREOF</b> <b>22 Sept. 1961</b>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>RICHLAND, VA.</b>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>RINALDI FUNERAL HOME, Inc.</b>   |  | <b>25a. REC'D BY REGISTRAR</b> <b>SEP 21 '61</b><br><b>25b. REGISTRAR'S SIGNATURE</b> <b>Carlton S. Kline</b>   |  |



1  
FOR STATE  
HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

| MONTGOMERY COUNTY   |  |  |  | MARYLAND  |  |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. LENGTH OF STAY IN 1b   |  |
| BETHESDA, MARYLAND  |  | DOA @ 1130   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | U.S. NAVAL HOSPITAL  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First Middle   |  | Last  |  |
| THOMAS ALDEN  |  | PUTNAM   |  |   |  |
| 5. SEX  |  | 6. COLOR OR RACE   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |  |
| MALE  |  | CAUC   |  | B. DATE OF BIRTH  |  |
|   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | MAY 31 1953   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)   |  |
| STUDENT   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
|   |  |  |  | USA   |  |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME   |  | Address   |  |
| WILLIAM J. PUTNAM   |  | BERTHA LEONE WEST  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |
| NO  |  | NONE   |  | FATHER  |  |
|   |  |  |  | 7111 FAIRFAX ROAD, BETHESDA, MD   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  | 19. WAS AUTOPSY PERFORMED?   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Exsanguination</u>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 912.0 DUE TO  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b) <u>Laceration of rt Axillary Artery</u>  |  |   |  |
|   |  | (c)  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY Month, Day, Year  |  |
|   |  | reported ran through a storm door  |  | 1117 P.M. 9-23-61   |  |
|   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |  |
|   |  | Residence  |  | Bethesda, Maryland Montg  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF   |  |
|   |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or country) (State)  |  |
|   |  | Arlington  |  | Arlington Va  |  |
| 23. GENERAL DIRECTOR  |  | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE  |  |
| Pulphrey  |  | DATE 245pt1961   |  | Arthur L. Kiana   |  |
| EXAMINER'S NAME (Type)  |  | BROSCHART, Frank J.  |  | DATE SIGNED 9-23-61   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

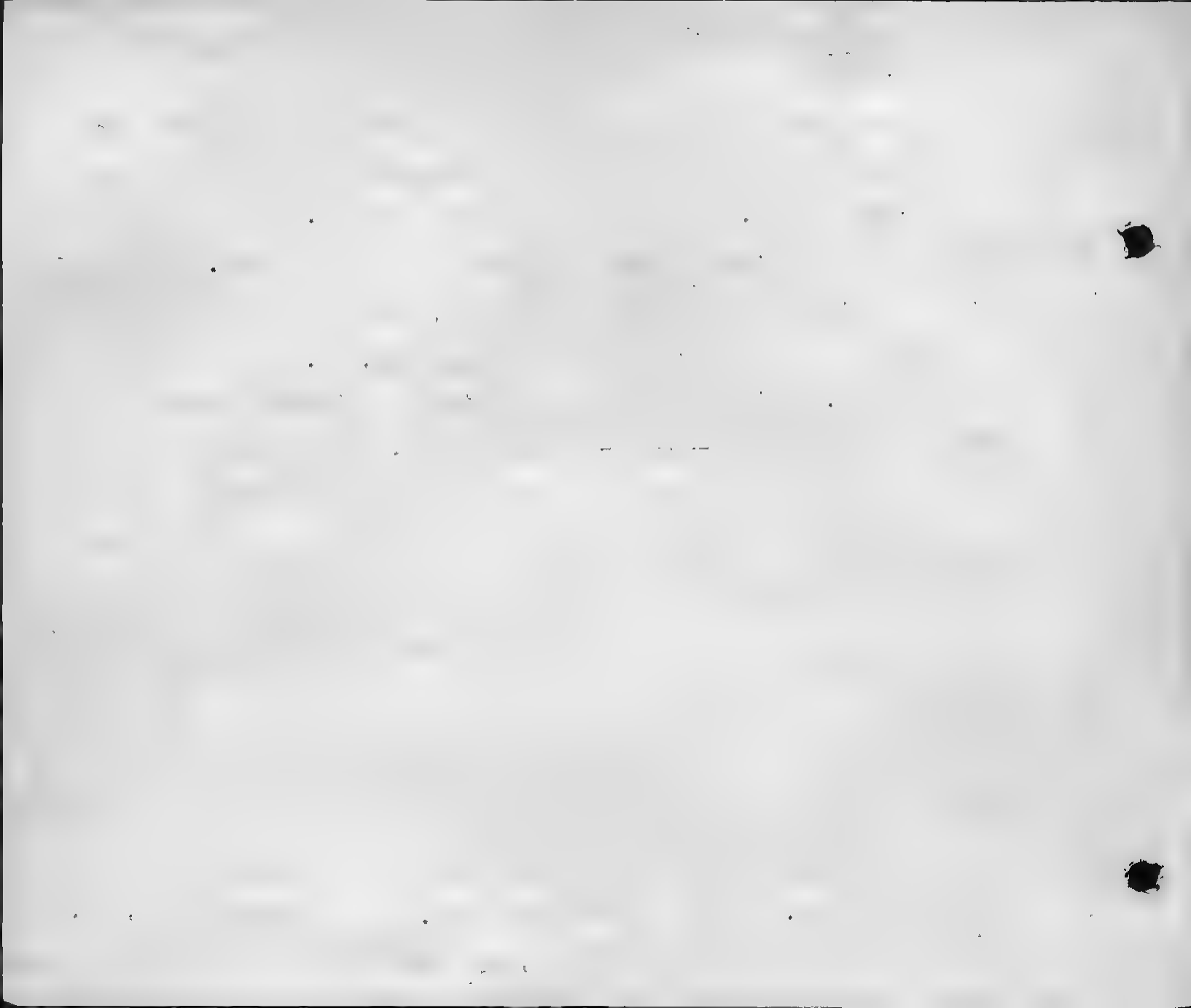
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10438

CERTIFICATE OF DEATH

10432

|   |  |   |   |
|---|--|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8800 Gue Rd.</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u><br>d. STREET ADDRESS <u>8800 Gue Rd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>William Edgar Reed</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>Sept.</u> Day <u>15</u> Year <u>1961</u>  |   |
| <b>5. SEX</b><br><u>Male</u>  | <b>6. COLOR OR RACE</b><br><u>White</u>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><u>June 21, 1887</u>   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Own Farm</u>   | <b>9. AGE</b> (In years last birthday) <u>74</u> yrs.<br>IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Damascus, Md.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u> |
| <b>13. FATHER'S NAME</b><br><u>Samuel P. Reed</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Matilda Williams Lydard</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b><br><u>Mrs Rhoda J. Reed, Item 2</u><br>Address <u>  </u>  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>31X</u> DUE TO <u>Cerebral Vascular Accident, recurrent</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arterio sclerosis</u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).<br><u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> years <u>  </u> |  |   |   |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>   | <b>20f. (City or town)</b> (County) (State)   |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 9</u> 19<u>61</u>, to <u>Sept. 15</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>9/15</u> 19<u>61</u>, and that death occurred at <u>9:15a</u> M, from the causes and on the date stated above.</b>   |  |   |   |
| <b>22a. SIGNATURE</b><br><u>G. F. Meadors</u> M.D.  |  | <b>22b. DATE SIGNED</b><br><u>5/15/61</u>   | <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>G. F. MEADORS, MD.</u>  |
| <b>22d. ADDRESS</b><br><u>DAMASCUS, MD.</u>   |  | <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |   |
| <b>23b. DATE THEREOF</b><br><u>Sept. 17, 1961</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Montgomery Meth.</u>  |   |
| <b>23d. LOCATION (City, town or county)</b><br><u>Claggettville, Md.</u>  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 18 '61</u>   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Oliver L. Mobaworth</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur L. Hanks</u>   |   |





CERTIFICATE OF DEATH

10433

Reg. Dist. No.

10439

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>b. COUNTY <u>md</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Opney</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc.</u>  |   | d. STREET ADDRESS <u>6406 Knollbrook Dr.</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>William Bernard Reilly</u>   |   | 4. DATE OF DEATH <u>Sept. 12 1961</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>           | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 6, 1894</u>                                       |
| 9. AGE (In years last birthday) <u>67</u> yrs   |   | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Guard for U.S. Supreme Court</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lowell, Mass.</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Daniel Reilly</u>  |   | 14. MOTHER'S MAIDEN NAME <u>unknown</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <u>6406 Knollbrook Dr. Hyattsville, Md.</u>  |  |
| 17. INFORMANT <u>Loretta F. Reilly</u>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Bronchopneumonia</u>  |   | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hemiplegia</u> DUE TO <u>8 yrs</u>   |   |  |  |
| (c) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>Yrs</u>  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |   | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Aug 7, 1961</u> to <u>Sept 12, 1961</u> , that I last saw the deceased alive on <u>Sept 11, 1961</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. |   |  |  |
| ACTUAL SIGNATURE <u>C. H. Ligon</u>   |   | ADDRESS (Street, city or town, state) <u>Sandy Spring MD</u>   |  |
| PHYSICIAN'S NAME (Type) <u>C. H. LIGON</u>  |   | DATE SIGNED <u>9/12/61</u>   |  |
| 22a. BURIAL, CREMATION, REPOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>Sept. 15, 1961</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Date of Heaven Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Montgomery County Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walton</u>   |   | 24a. REC'D BY REGISTRAR <u>SEP 14 '61</u>  |  |
| ADDRESS <u>254 Carroll St NW. D.C.</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10440

10434

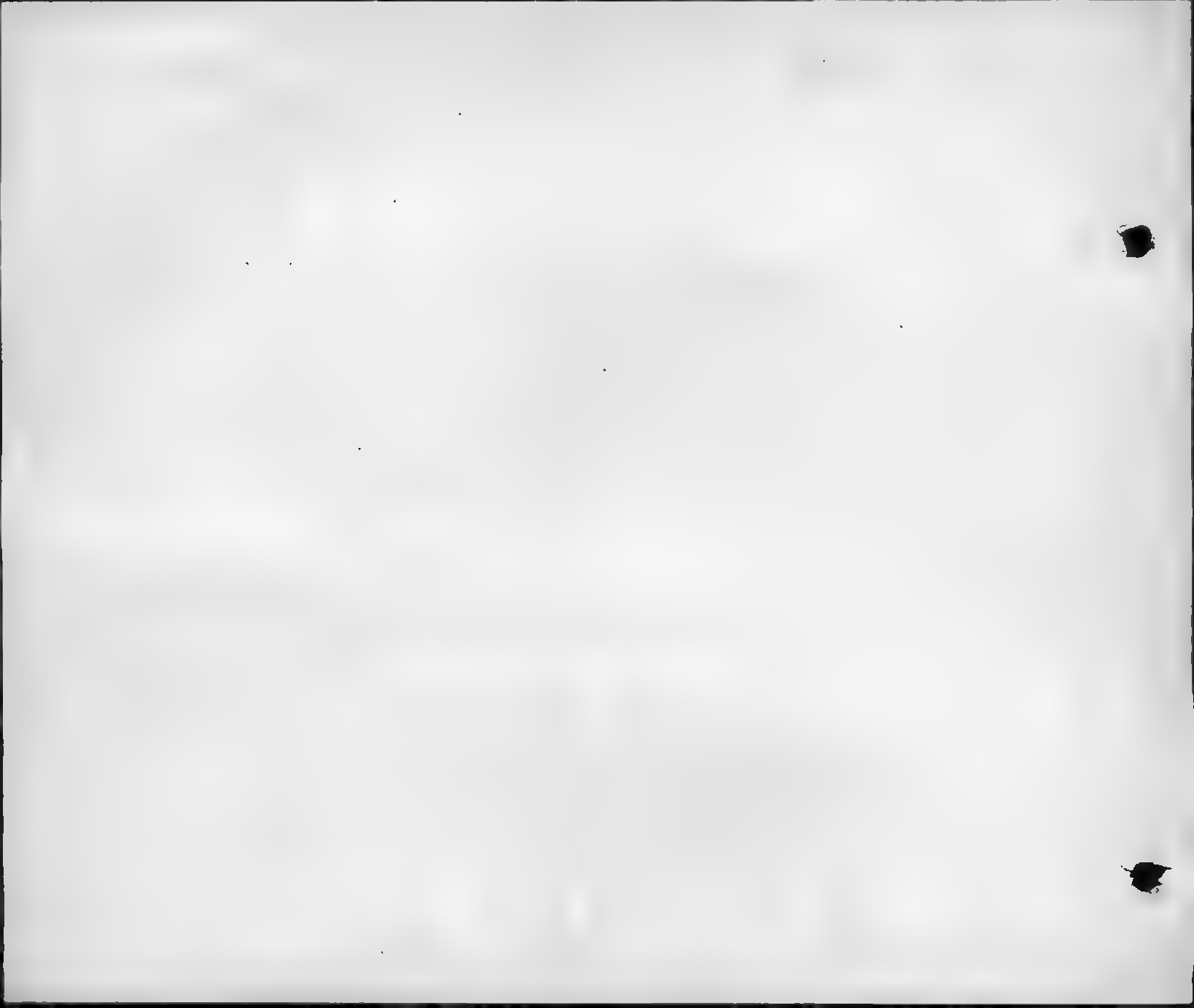
|  |                           |  |                                       |   |                             |  |  |
|--|---------------------------|--|---------------------------------------|---|-----------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                           |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY |                             |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takehome Park</u>  |                           |  |                                       | c. LENGTH OF STAY IN lb <u>3 months</u>   |                             |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home</u>  |                           |  |                                       | d. STREET ADDRESS <u>4226-31st S.</u>   |                             |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Eliahan</u> Middle <u>Richard</u> Last <u>Richard</u>   |                           |  |                                       | 4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1961</u>   |                             |  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 8, 1872</u> | 9. AGE (In years last birthday) <u>89</u> yrs   | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>   |                                       | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>   |                             | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>William Henry Richard</u>   |                           |  |                                       | 14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Keffer</u>  |                             |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>  |                           | 16. SOCIAL SECURITY NO <u>—</u>  |                                       | 17. INFORMANT Address <u>Mrs. Mary Ann Richards, 4226-31st S. Mt Rainier Md.</u>  |                             |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebral thrombus</u><br>X DUE TO (b) <u>Arteriosclerosis, cerebral</u><br>DUE TO (c) <u>?</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |                           |  |                                       |   |                             | INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):  |                           |  |                                       |   |                             | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                       |   |                             |  |  |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19   |                           | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                             | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> , 19 <u>61</u> to <u>9/10</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/8</u> , 19 <u>61</u> , and that death occurred at <u>3:15</u> PM, from the causes and on the date stated above                                  |                           |  |                                       |   |                             |  |  |
| 22a. SIGNATURE <u>Chas H. Voloshin</u>   |                           |  |                                       | 22b. DATE SIGNED  |                             |  |  |
| 22c. PHYSICIAN'S NAME (Type, <u>Chas H. Voloshin</u> )   |                           |  |                                       | 22d. ADDRESS <u>7401 Blair Rd NW</u>  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 23b. DATE THEREOF <u>9/12/61</u>   |                                       | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Methodist Church Cemetery</u>  |                             | 23d. LOCATION (City, town, or county) (State) <u>Mountain Falls, Va.</u>                       |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home Inc.</u>   |                           |  |                                       | 25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>   |                             | 25b. REGISTRAR'S SIGNATURE <u>William L. Finney</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

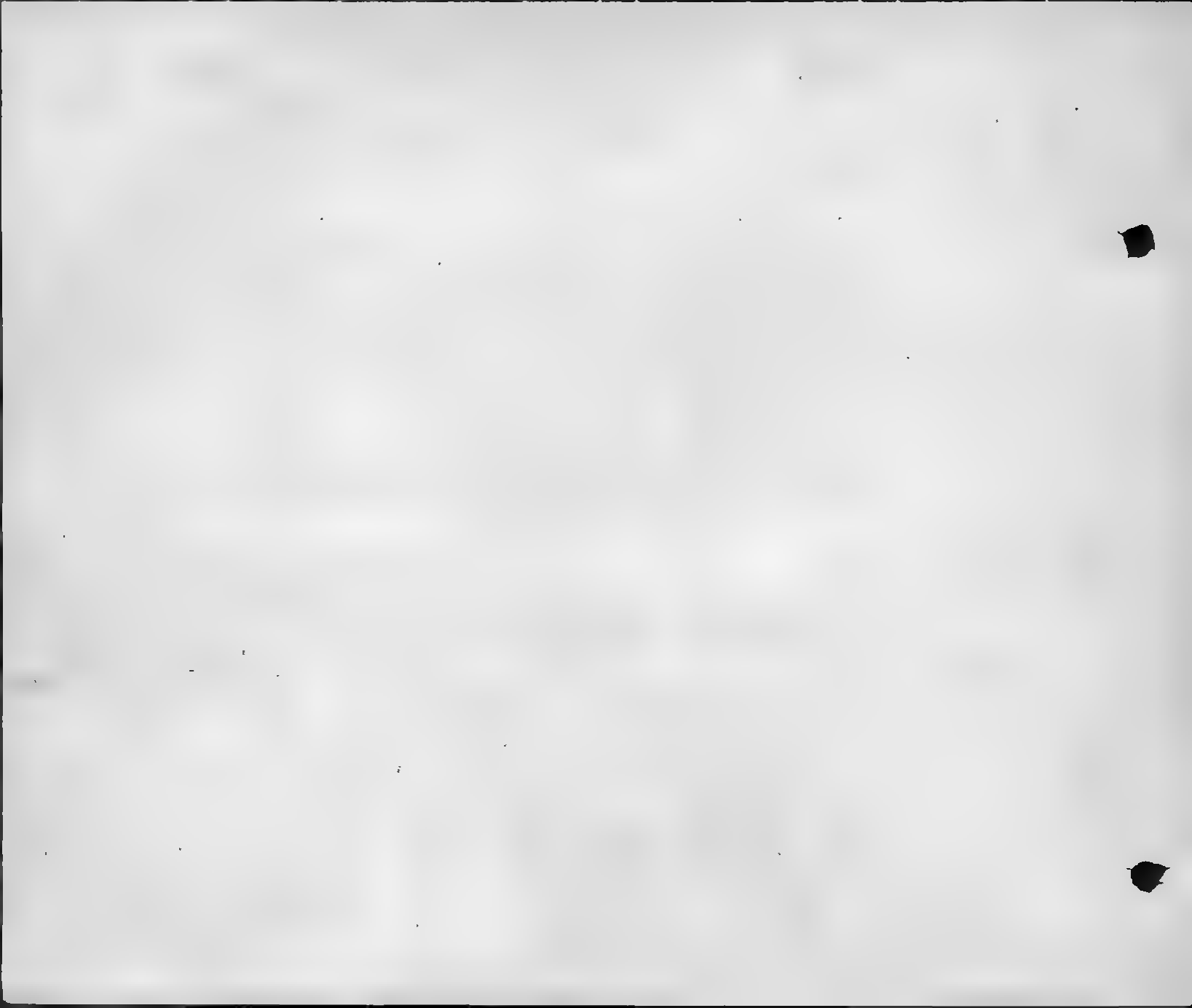
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10441

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 10435

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b><br>c. LENGTH OF STAY IN b<br><b>Four hrs.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Washington Sanitarium and Hospital</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>DC</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b><br>d. STREET ADDRESS<br><b>601 North Dakota Ave. NW</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Micheline (NMN) Ricucci</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>September 11 1961</b>  |                                    |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>3-18-95</b> |
| 9. AGE (in years last birthday)<br><b>66</b> yrs.  |                                  | 10. IF UNDER 1 YEAR Months Days<br><b>66</b>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Italy</b>   |                                    |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Italy</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.M.</b>   |                                    |
| 13. FATHER'S NAME<br><b>Gennaro Petrosino</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Consiglia Pepe</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>no</b>   |                                    |
| 17. INFORMANT<br><b>Hospital Records</b>   |                                  | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4</b> DUE TO <b>Coronary Occlusion Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Diabetes Mellitus</b> |                                  |   |                                    |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>case cleared with Coroner Brodhat</b>   |                                  |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town, County) (State)   |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-11-1961</b> to <b>9-11-1961</b> , that (I) (we) last saw the deceased alive on <b>9/11/1961</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.  |                                  |   |                                    |
| 22a. SIGNATURE<br><b>Robert A. Hare MD.</b>  |                                  | 22b. DATE SIGNED  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert A. Hare MD.</b>  |                                  | 22d. ADDRESS<br><b>7600 Carroll Ave., TP, Md.</b>   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/11/61</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Prince Georges County, Md.</b>   |                                    |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>The D. H. Hare Co.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>SEP 13 '61</b>  |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hare</b>  |                                  |   |                                    |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10436

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b DOA.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hosp

2. USUAL RESIDENCE (Where deceased lived, if not full-time: Residence before admission)  
a. STATE md b. COUNTY montg  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton  
d. STREET ADDRESS 12611 Yould Rd

3. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4. DATE OF DEATH  
Month Sept Day 23 Year 1961

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 6-22-1902 9. AGE (in years last birthday) 59 yrs. IF UNDER 1 YEAR: Months 5 Days 23 Hours 19 Min. IF UNDER 24 HRS. Months 5 Days 23 Hours 19 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ad. Salesman 10b. KIND OF BUSINESS OR INDUSTRY WOMR Radio Station 11. BIRTHPLACE (State or foreign country) Conn. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Herman Rogers 14. MOTHER'S MAIDEN NAME Julia Augusta Brower

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. 16. SOCIAL SECURITY NO. 578-07-9443 17. INFORMANT Edwin L. Rogers Jr. Address 12910 Evanson St Rockville md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary occlusion  
DUE TO hypertension  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c) sudden  
INTERVAL BETWEEN ONSET AND DEATH years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 4201 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

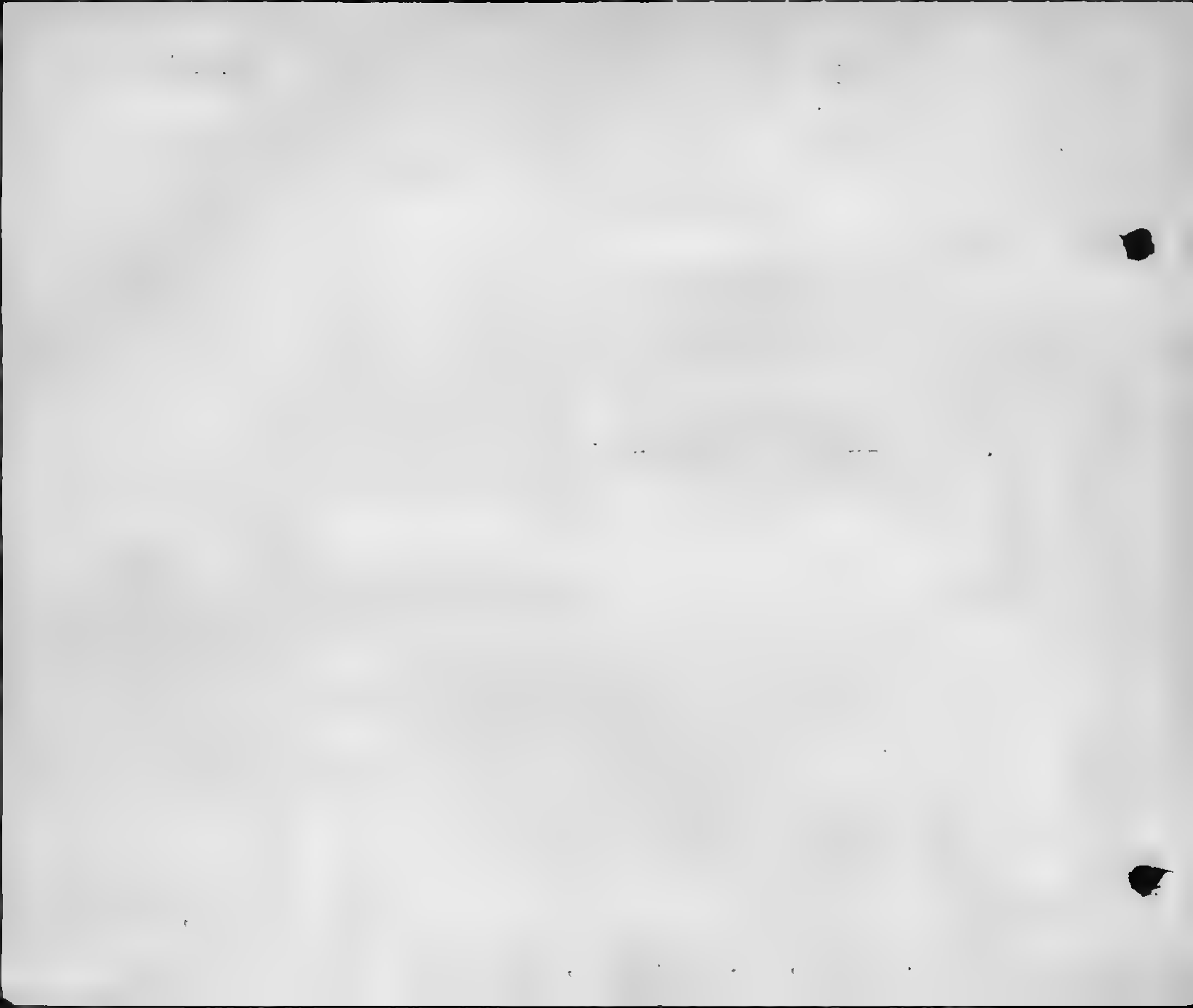
ACTUAL SIGNATURE Frank J. Broschart DATE SIGNED 9-23-61  
EXAMINER'S NAME (Type) FRANK J. Broschart Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/26/61 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or country) (State) Montgomery County, Maryland

23. FUNERAL DIRECTOR Raymond A. Ziska ADDRESS 8434 Georgia Avenue 24a. REC'D BY REGISTRAR SEP 26 '61 24b. REGISTRAR'S SIGNATURE Charles P. Thomas

VS. A15ME  
5M 9 60

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

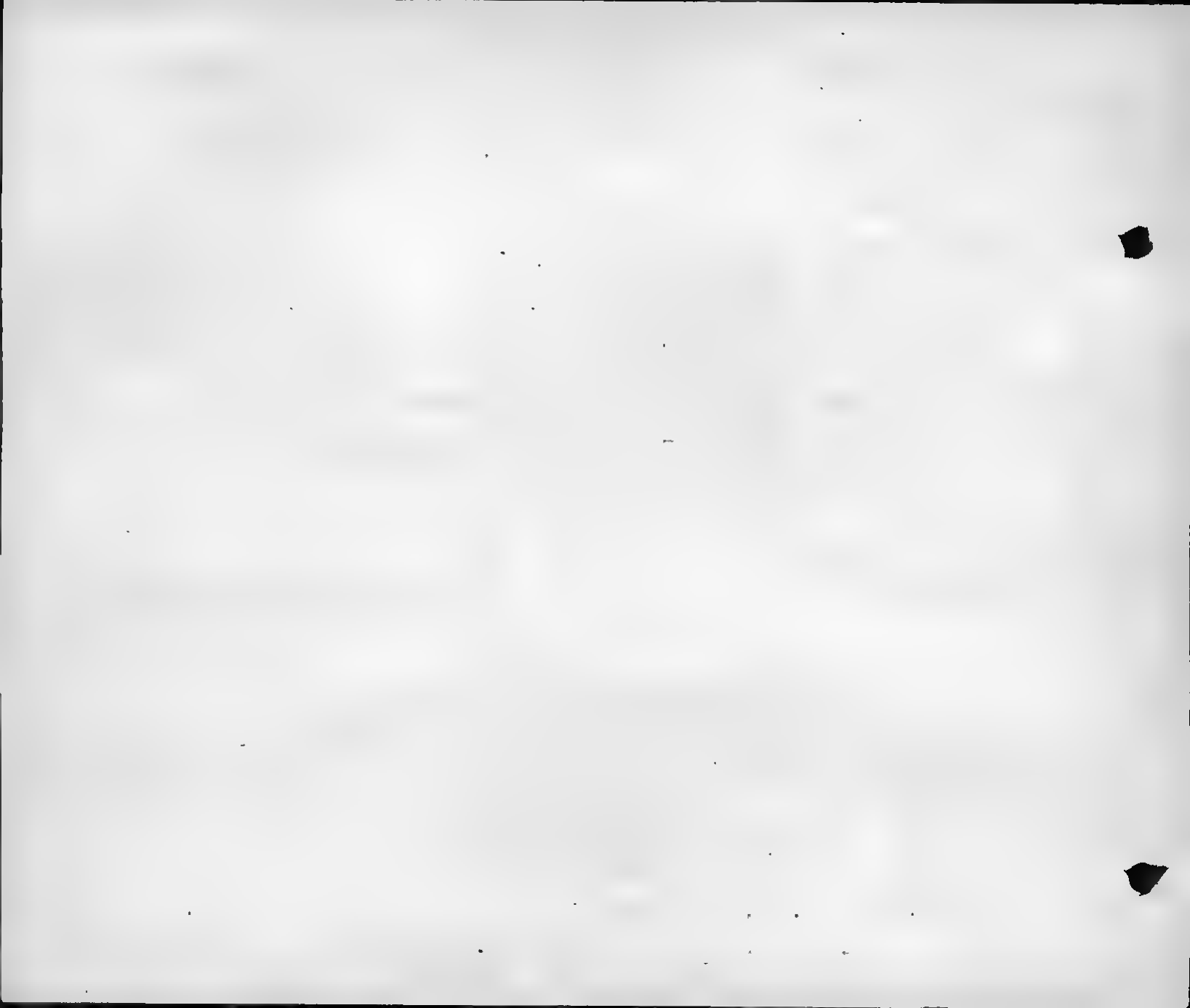
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|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>o. STATE <u>Tenn</u> b. COUNTY <u>✓</u>                                    |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clney</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Daylight</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brokee Grove foundation</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Joel</u> Middle <u>Cyrus</u> Last <u>Rogers</u>  |  |  |  | 4. DATE OF DEATH Month <u>Sept</u> Day <u>13</u> Year <u>1961</u>   |  |  |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>Cauc</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Sept 24 1865</u>   |  |
| 9. AGE (In years last birthday) <u>95</u> yrs.  |  | 10. IF UNDER 1 YEAR Months <u>9</u> Days <u>13</u> Hours <u>15</u> Min.                                |  | 11. IF UNDER 24 HRS   |  |  |  |
| 10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Clergy</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Micha</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u>  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME <u>Soloman Rogers</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Jane Terrill</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <u>•</u>  |  | 17. INFORMANT <u>J C Rogers</u> Address <u></u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1753</u> DUE TO <u>cardiac failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sen. art. Schraus</u> DUE TO <u></u><br>(c) <u></u> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u><br><u>15 yrs</u>                                 |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u><br>Hour a. m. <u></u> p. m. <u></u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1 June 1954</u> to <u>15 Sept 1961</u> , that (I) (we) last saw the deceased alive on <u>15 Sept 1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| 22a. SIGNATURE <u>John Beasley Ziegler</u> M.D.   |  |  |  | 22b. ADDRESS <u>OLNEY</u> M.D.  |  | 22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER MD</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>Sept. 18, 1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>                         |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Packer</u>   |  |  |  | 25a. REC'D BY REGISTRAR <u>SEP 13 1961</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Clara L. Housh</u>   |  |

(M)

(I)



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10438

18  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake  
c. LENGTH OF STAY IN TOWN 15 yrs  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5710 Surrey st

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE md b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake  
d. STREET ADDRESS 5710 Surrey st  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Calbot Mercer Rogers  
First Middle Last  
4. DATE OF DEATH Sept 15 1961 Month Day Year

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH 1-19-1907 9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect  
10b. KIND OF BUSINESS OR INDUSTRY Pal  
11. BIRTHPLACE (State or foreign country) Pa  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Rogers 14. MOTHER'S MAIDEN NAME Agnes Klemm  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give branch or dates of service) No  
16. SOCIAL SECURITY NO Unknown 17. INFORMANT Janet Rogers (wife) Address Stm 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Asphyxia DUE TO  
97311  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }  
(b) Carbon monoxide poisoning DUE TO  
(c) \_\_\_\_\_  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) \_\_\_\_\_  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall dead in car - horse attached to exhaust.  
20c. TIME OF INJURY Month Day Year 7-9-15-1961 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) home 20f. (City or town) Chesapeake (County) Montgomery (State) md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brosechew EXAMINER'S NAME (Type) FRANK J. BROSECHEW  
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒  
DATE SIGNED 9-15-61  
Address (Street, city, town or county) \_\_\_\_\_

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 22b. DATE THEREOF 9-18-61 22c. NAME OF CEMETERY OR CREMATORY Valley Forge Cem. 22d. LOCATION (City, town, or country) (State) Valley Forge, Penna

23. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS Bethesda, Md.  
24a. REC'D BY REGISTRAR SEP 20 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



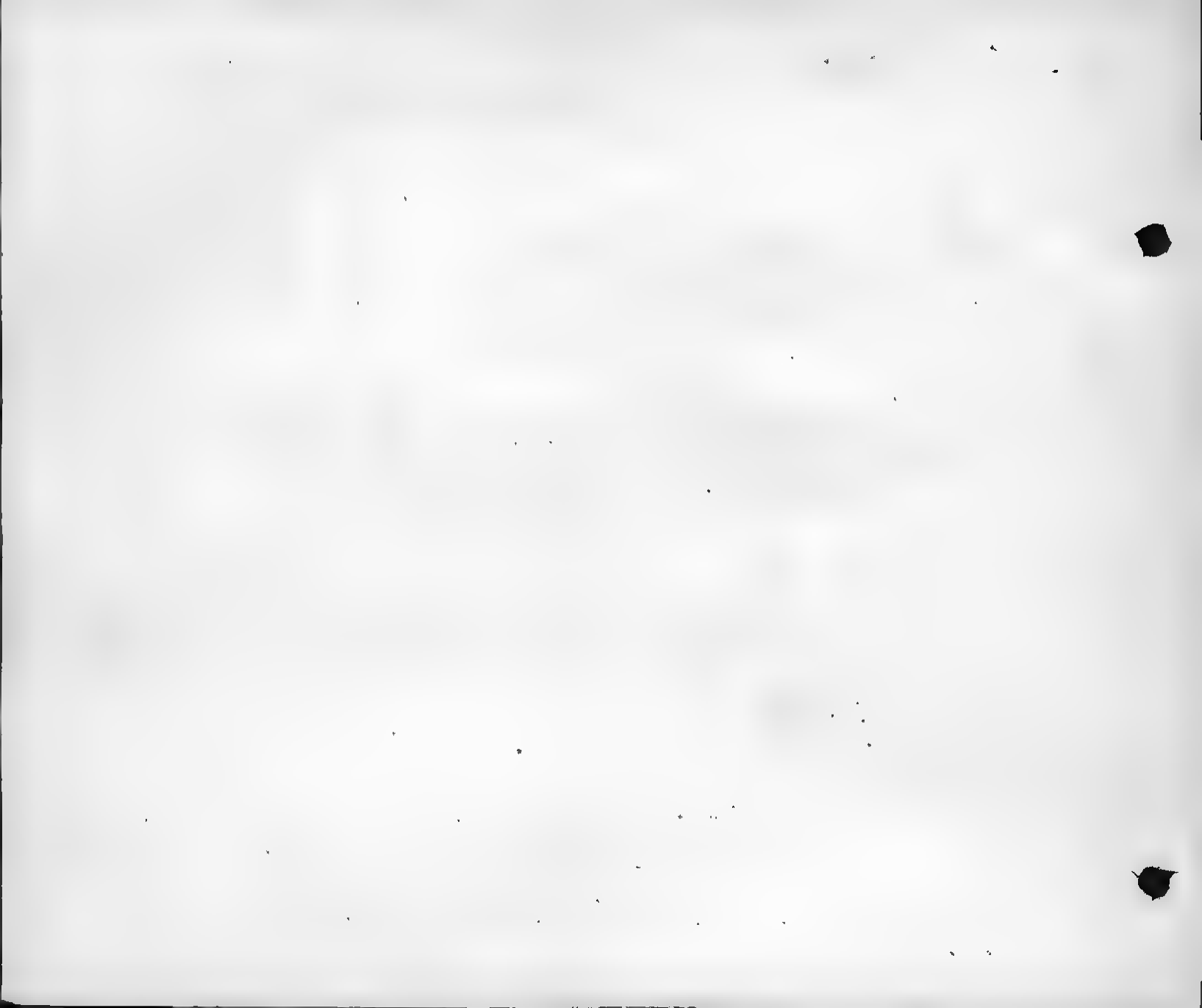
## CERTIFICATE OF DEATH

10439 No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>b. STATE <u>D. C. MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda / Washington</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Resmor San. &amp; Hosp.</u>  |                                  | d. STREET ADDRESS <u>3721 Jenifer St. NW</u><br><u>1411 1/2 N. 15th St. N.W.</u>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>LILLIE ROSENTHAL</u>  |                                  | 4. DATE OF DEATH Month Day Year<br><u>Sept. 3, 1961</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            | 8. DATE OF BIRTH<br><u>Sept. 2, 1873</u> |
| 9. AGE (1st years last birthday) yrs<br><u>88</u>   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>New York</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  |
| 13. FATHER'S NAME<br><u>Nathan Bernstein</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Leah Cohen</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>—</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>—</u>  |  |
| INFORMANT<br><u>Mrs. M. Levitan - 3721 Jenifer St. N.W. Wash. D.C.</u>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial failure</u><br><u>150.</u> DUE TO<br>Conditions, if any which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u><br><u>10 years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month Day Year<br>Hour a. m. <u>5:05</u> p. m. <u>—</u>   |                                  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>1938</u> to <u>9/3/61</u> , that I last saw the deceased alive on <u>9/2/61</u> , 19 <u>—</u> , and that death occurred at <u>5:05</u> p. m. from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <u>Herbert Abramson</u> M.D.   |                                  | ADDRESS (Street, city or town, state) <u>1712 - EYE ST. N.W.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>HERBERT ABRAMSON, M.D.</u>   |                                  | <u>WASH. D.C.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>9/5/61</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Adas Israel Cem.</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Wash. D.C.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>B. DANZANSKY &amp; SONS</u>  |                                  | ADDRESS<br><u>WASH. D.C.</u>   |  |
| 24a. REC'D BY REGISTRAR<br><u>SEP 7 '61</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



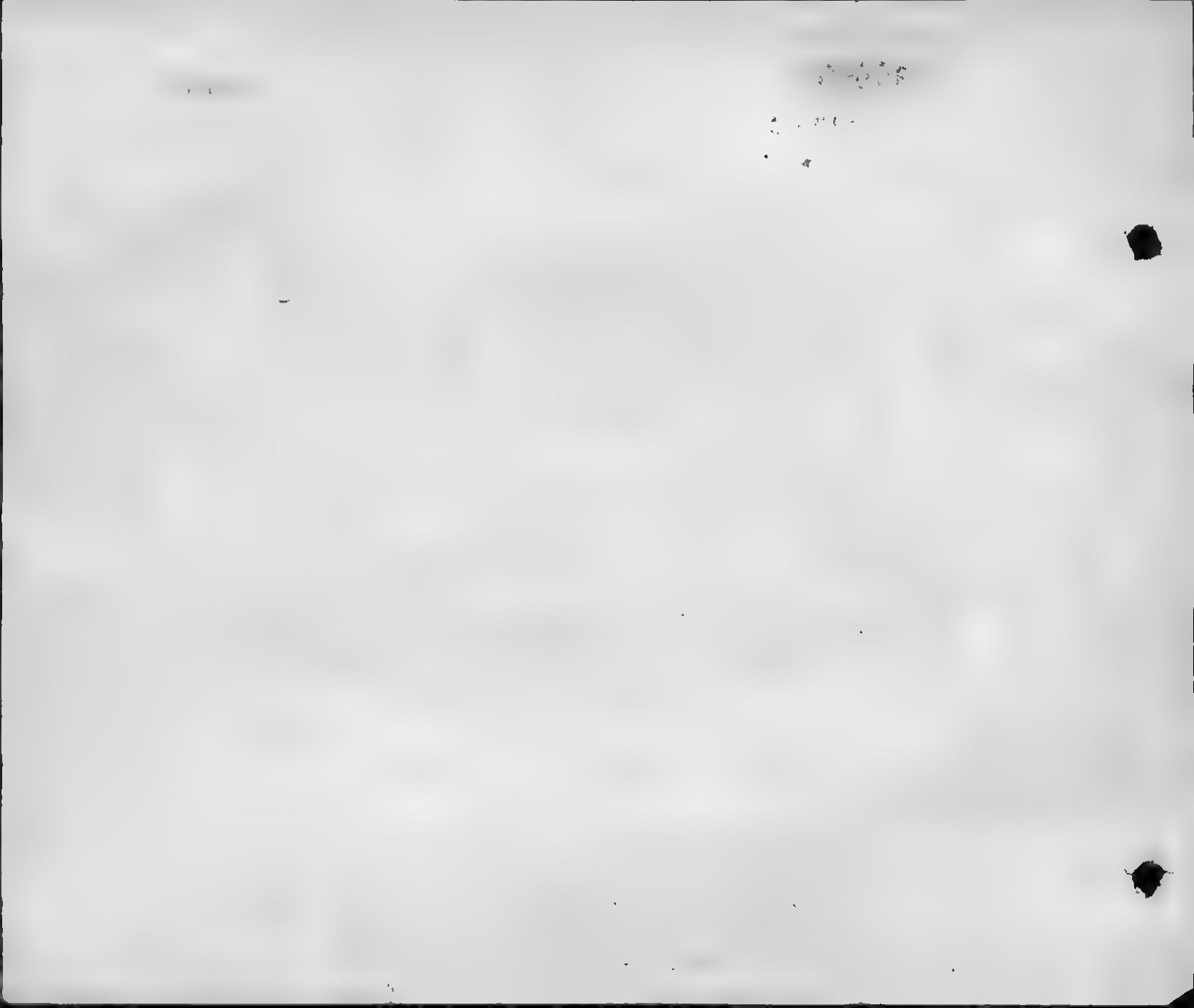
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |                               |   |  |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>e. COUNTY <u>MONTGOMERY</u><br>f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton - Md.</u><br>g. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>                                    |                               | 2. USUAL RESIDENCE (Where deceased lived, if not usual residence before admission)<br>e. STATE <u>Md.</u><br>f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u><br>g. STREET ADDRESS <u>37 West Lenox St</u>                                       |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>John Gould Rouse, Sr</u>   |                               | 4. DATE OF DEATH <u>Sept 26 1961</u>  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>April 25-1884</u><br>9. AGE (In years, last birthday) <u>77</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Federal Housing</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>  |  |
| 11. FATHER'S NAME <u>Wm C. Rouse</u>   |                               | 12. C. TIZEN OF WHAT COUNTRY? <u>U. S.</u>  |  |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                               | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Murphy</u>  |  |
| 15. SOCIAL SECURITY NO.  |                               | 16. INFORMANT Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause, or line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Captured Aortic Aneurysm</u><br>DUE TO (b) <u>Arteriosclerosis</u><br>CONDITIONS, any which gave rise to immediate cause (a), stating the underlying cause last. (c) |                               |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).<br><u>Cerebrovascular Accident - Left Hemisphere</u>  |                               |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               | 20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 12, 1961</u> to <u>Sept 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 24, 1961</u> , and that death occurred at <u>home</u> , from the causes and on the date stated above.                              |                               | 22. SIGNATURE <u>John T. Hagenbuecher</u><br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22a. PHYSICIAN'S NAME (Type) <u>John T. Hagenbuecher</u><br>22b. ADDRESS <u>915 19th St., N.W. Wash., D.C.</u> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>   |                               | 23b. DATE THEREOF <u>9-29-1961</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>   |                               | 23d. LOCATION (City, town or county) <u>BALTIMORE, MD.</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudreault, Jr.</u><br>ADDRESS <u>1756 - Park Ave. NW</u>   |                               | 25a. REC'D BY REGISTRAR <u>SEP 28 '61</u><br>25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10447

10441

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Montgomery   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE<br>Virginia |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)  |  | b. COUNTY<br>Virginia  |  |
| c. LENGTH OF STAY IN 1b<br>42 days  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Falls Church                     |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U. S. Naval Hospital  |  | d. STREET ADDRESS<br>1019 Cedar Lane   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First Middle Last<br>Mary Agnes Runyon   |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br>September 28 1961   |  |
| 5. SEX<br>Female  |  | 6. DATE OF BIRTH<br>4-10-88  |  |
| 7. COLOR OR RACE<br>Caucasian   |  | 9. AGE (in years last birthday)<br>73 yrs.   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Pennsylvania  |  |
| 13. FATHER'S NAME<br>Frank Roddy  |  | 14. MOTHER'S MAIDEN NAME<br>Kate Hassan  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.<br>545-32-8813D  |  |
| 17. INFORMANT<br>Mrs. Margaret B. Lark, same as #2 above  |  | Address  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last, (c)<br>DUE TO<br>Carcinoma of Stomach |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                           |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (this hospital) attended the deceased from August 17, 1961, to Sept. 28, 1961, that (X) (we) last saw the deceased alive on Sept. 28, 1961, and that death occurred 3:45 AM, from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br>C. W. Bramlett  |  | 22b. DATE SIGNED<br>September 28, 1961   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>C. W. BRAMLETT, LCDR MC USN   |  | 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE THEREOF<br>30 Sept 1961  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery   |  | 23d. LOCATION (City, town or county) (State)<br>Philadelphia, Pa   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Robert J. Murphy  |  | 25a. REC'D BY REGISTRAR<br>SEP 29 '61  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus   |  | 25c. ADDRESS<br>3524 Columbia Pike, Arlington, Va.   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

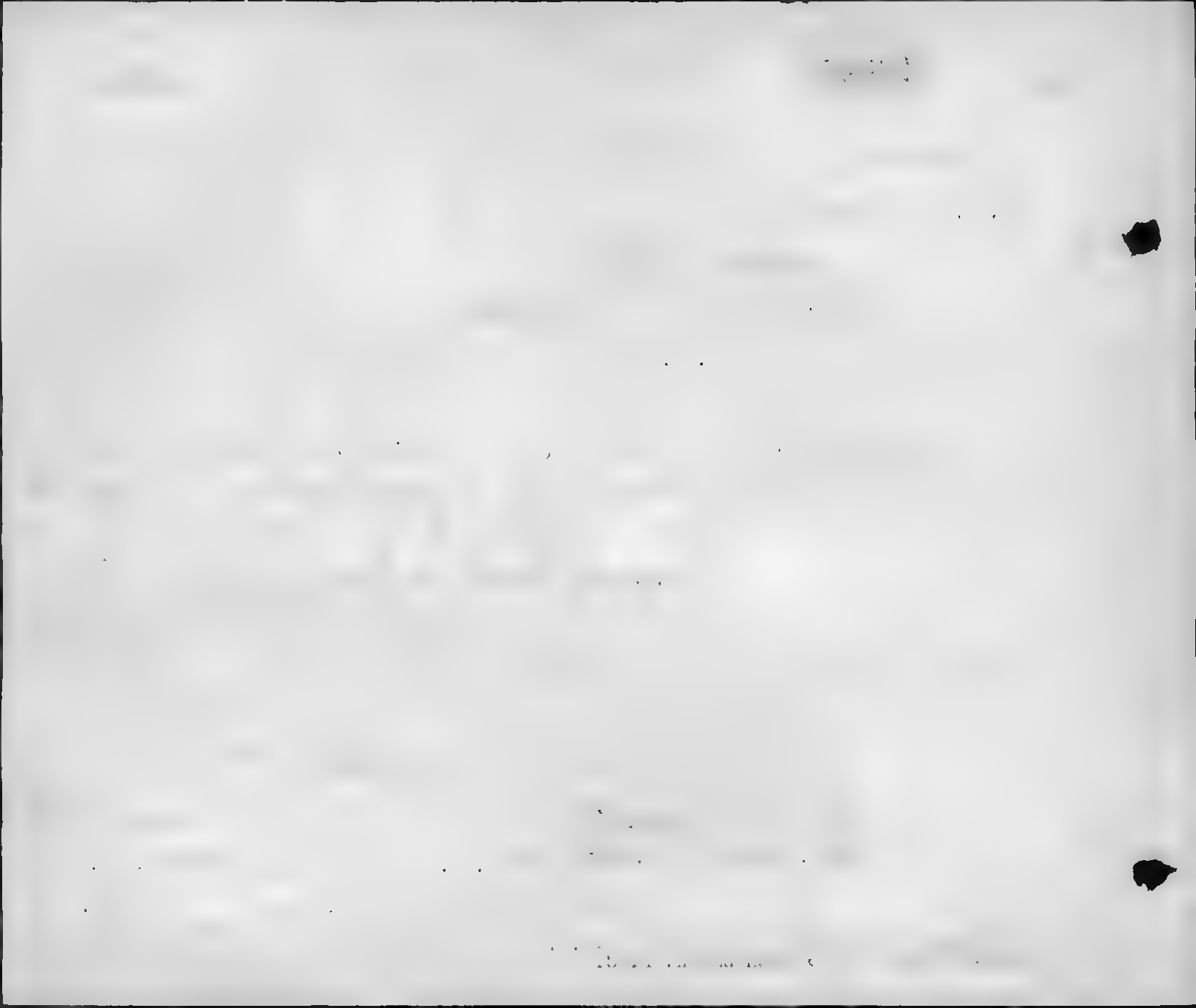
**10448**

Item 14 Film 6295 9/19/61 ink

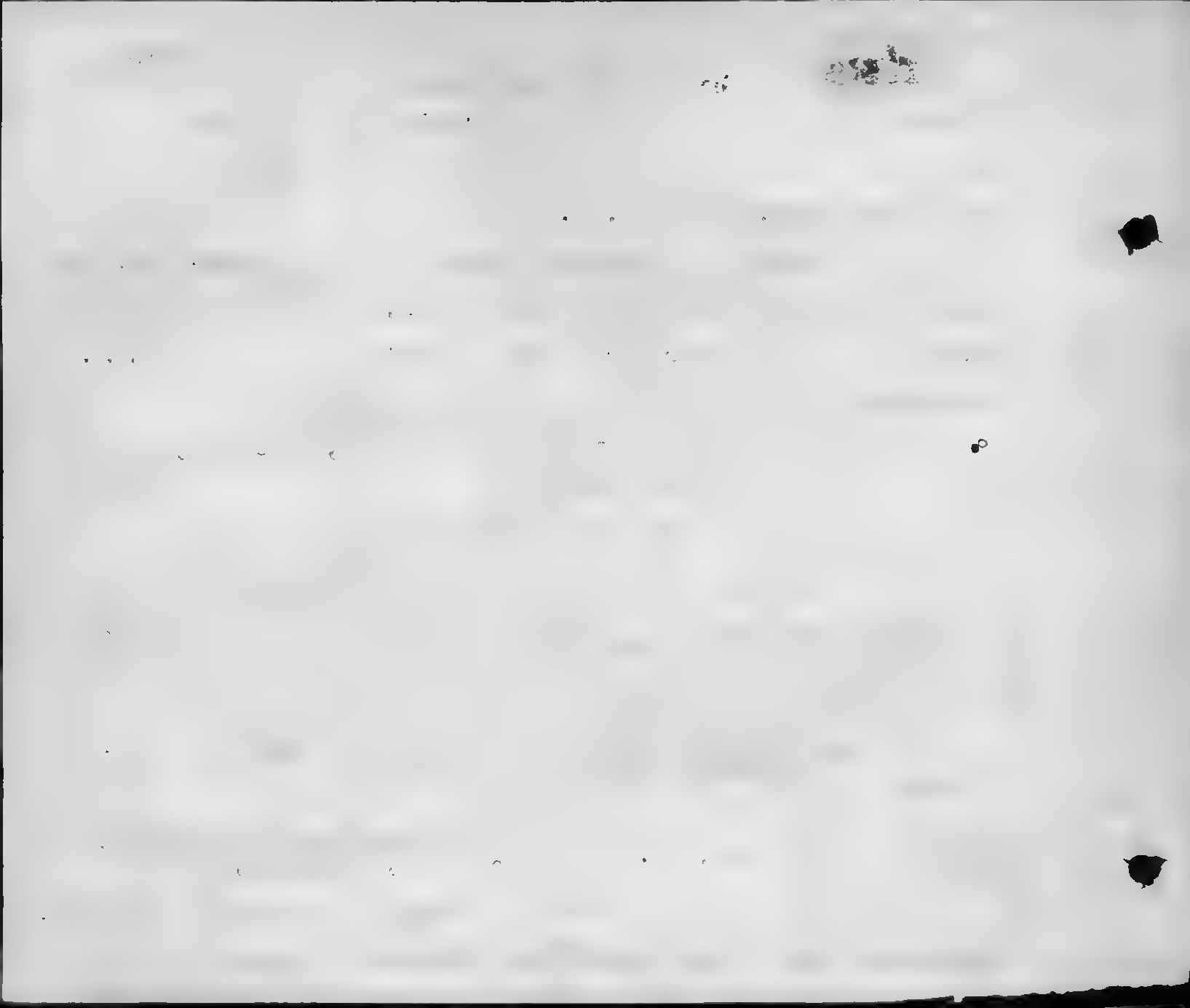
**10442**

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|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Montgomery  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution residence under admission)<br>a. STATE<br>Virginia<br>b. COUNTY<br>Leon  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |  | c. LENGTH OF STAY IN lb<br>12 days<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Leon   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U. S. Naval Hospital   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First Middle Last<br>Edmond Julius Ruth   |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br>September 7 19 61   |  |
| <b>5. SEX</b><br>Male  |  | <b>6. COLOR OR RACE</b><br>Caucasian   |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br>6-16-07   |  |
| <b>9. AGE</b> (In years last birthday)<br>54 yrs.  |  | <b>10. AGE</b> (In years last birthday)<br>54 yrs.   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Armed Forces   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>U. S. Navy   |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br>Louisiana  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>USA   |  |
| <b>13. FATHER'S NAME</b><br>Henry John Ruth  |  | <b>14. MOTHER'S MAIDEN NAME</b><br>unknown   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br>Yes WWII & Korea  |  | <b>16. SOCIAL SECURITY NO.</b><br>577 40 2187  |  |
| <b>17. INFORMANT</b><br>(Wife) Josephine R. Ruth Same as #2 above  |  | <b>18. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>uremia and septicemia</u><br>DUE TO (b) <u>chronic glomerulonephritis</u><br>DUE TO (c) <u>neurogenic bladder + paraplegia</u> |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 wks<br>9 yrs.<br>9 yrs.  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m.<br>19  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that</b> (X) (this hospital) attended the deceased from August 26, 1961, to September 7, 1961, that (1) (we) last saw the deceased alive on September 7, 1961, and that death occurred at 1:10 PM from the causes and on the date stated above. |  |  |  |
| <b>22a. SIGNATURE</b><br>John W. Brackett, Jr. M.D.  |  | <b>22b. DATE SIGNED</b><br>8 September 1961  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br>JOHN W. BRACKETT, JR. LT MSC USN  |  | <b>22d. ADDRESS</b><br>U. S. Naval Hospital, Bethesda, Md.   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>Burial   |  | <b>23b. DATE THEREOF</b><br>11 Sept 1961   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>Arlington National  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br>Arlington Va.   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br>Deal Funeral Home, Washington, D. C.  |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE SEP 11 '61  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br>Arthur S. Kraus   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**10444**

**10450**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <i>DC</i> b. COUNTY |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Olney</i>   |  | c. LENGTH OF STAY IN 1b <i>3yr 5mo</i>   |  |
| d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>Sharon Nursing Home Brooke Crook Foundation</i>   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>                   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Gertrude B Sappington</i>  |  | f. STREET ADDRESS <i>4312 Valley Terrace SE</i>  |  |
| 5 SEX <i>Female</i>   |  | 6 COLOR OR RACE <i>Cauc</i>  |  |
| 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <i>Nov 12 1876</i>  |  |
| 9. AGE (in years last birthday) <i>84</i> yrs   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                           |  |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |  | 12. CITIZEN OF WHAT COUNTRY? <i>US</i>   |  |
| 13. FATHER'S NAME <i>James B Sappington</i>   |  | 14. MOTHER'S MAIDEN NAME <i>Gertrude Craddock</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <i>James Markland</i>   |  | Address <i>Alexandria Va 3778 Gunston Rd</i>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i><br>DUE TO (b) <i>Atherosclerosis Generalized</i><br>DUE TO (c)<br>Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>               |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21 I certify that (I) (this hospital) attended the deceased from <i>Oct 1961</i> to <i>Sept 30 1961</i> , that (I) (we) last saw the deceased alive on <i>9/30 1961</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above   |  |  |  |
| 22a. SIGNATURE <i>[Signature]</i>   |  | 22b. DATE SIGNED <i>9/30/61</i>  |  |
| 22c. PHYSICIAN'S NAME (Type) <i>C. H. H. Wilson</i>   |  | 22d. ADDRESS <i>Wash D.C.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL TO CHURCH   |  | 23b. DATE THEREOF <i>10/4/61</i>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Chester Cemetery</i>  |  | 23d. LOCATION (City, town, or county) (State) <i>Chestertown, Md.</i>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Rines Co., 2901 14th St. N.W.,</i>   |  | 25a. REC'D BY REGISTRAR <i>OCT 3 '61</i>   |  |
| 25b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

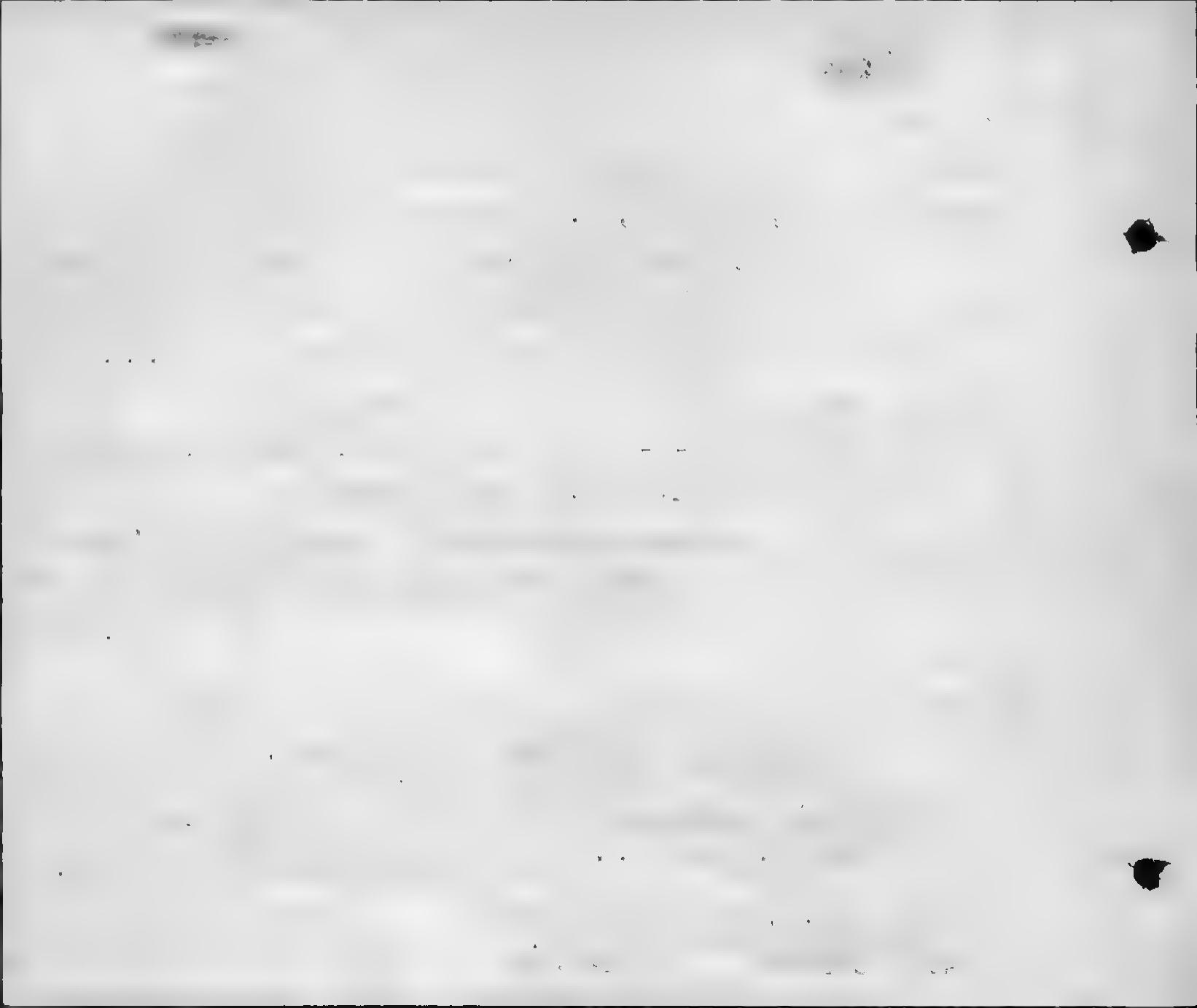




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VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND   |  |  |  |   |  |  |  |  |  |  |  |
| 10451  |  |  |  |   |  |  |  |  |  |  |  |
| 10445  |  |  |  |   |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>b. STATE<br>Virginia |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda   |  |  |  | c. LENGTH OF STAY IN IN<br>38 days  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Arlington  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.  |  |  |  | 5922 North 14th Street  |  |  |  | d. STREET ADDRESS  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>Maryjane Anderson   |  |  |  | 4. DATE OF DEATH<br>September 30 19 61  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 5. SEX<br>Female   |  |  |  | 6. COLOR OR RACE<br>White   |  |  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Legal Secretary   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Law  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Massachusetts   |  |  |  |
| 13. FATHER'S NAME<br>Thomas D. Murray  |  |  |  | 14. MOTHER'S MAIDEN NAME<br>Barbara Carr  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |  |  |  | 16. SOCIAL SECURITY NO.<br>030-09-2198  |  |  |  | 17. INFORMANT<br>The Medical Record  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u><br>17 <u>Widespread metastatic carcinoma of the uterine cervix (lung, liver, bone)</u><br>DUE TO (b) <u>1 year</u><br>DUE TO (c) <u>6-7 months</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hours</u>  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)                   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m.<br>p.m.<br>19   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>     |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.)  |  |  |  |
| 20f. (City or town)<br>Arlington   |  |  |  | 20g. (County)<br>Arlington  |  |  |  | 20h. (State)<br>Virginia   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from August 23, 1961, to Sept. 30, 1961, that (I) (we) last saw the deceased alive on Sept. 30, 1961, and that death occurred at 4:00 AM on the causes and on the date stated above.  |  |  |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br>Robert H. Wilkins  |  |  |  | 22b. DATE SIGNED<br>9-30-61   |  |  |  | 22c. PHYSICIAN'S NAME (Type)<br>Robert H. Wilkins M.D.   |  |  |  |
| 22d. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda 14, Md.   |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  | 23b. DATE THEREOF<br>Oct. 3, 1961   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Columbia Gardens   |  |  |  |
| 23d. LOCATION (City, town or county)<br>Arlington, Virginia  |  |  |  |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>By: C.M. Samuel  |  |  |  | 24a. ADDRESS<br>2847 Wilson Blvd.<br>Arlington, Va.   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>Oct 3 1961  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>William S. ...   |  |  |  |   |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

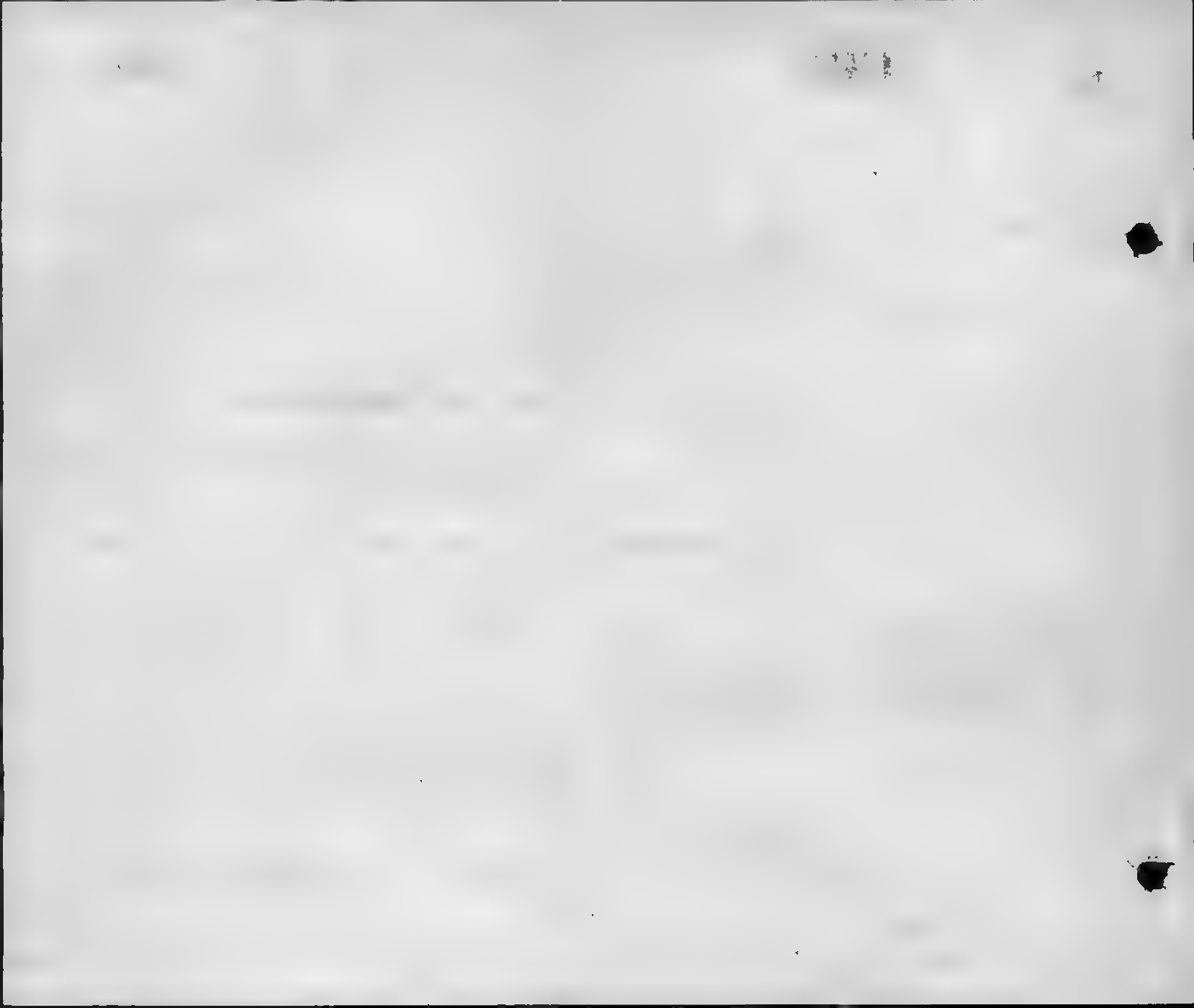
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |                      |  |  |  |       |  |  |  |
|---|--|--|--|----------------------|--|--|--|-------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |                      |  |  |  |       |  |  |  |
| 10453   |  |  |  | CERTIFICATE OF DEATH |  |  |  | 10447 |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  |  |  |                      |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Massachusetts</u> b. COUNTY <u>Everett</u>  |  |       |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |  |  |                      |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Everett</u>  |  |       |  |  |  |
| c. LENGTH OF STAY IN IL <u>12 Days</u>  |  |  |  |                      |  | d. STREET ADDRESS <u>39 Lawrence Street</u>  |  |       |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>   |  |  |  |                      |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |       |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Evelyn</u> <u>None</u>   |  |  |  |                      |  | 4. DATE OF DEATH <u>September 25, 19 61</u>  |  |       |  |  |  |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  |  |  |                      |  | 8. DATE OF BIRTH <u>February 6, 1918</u> 9. AGE (In years last birthday) <u>43</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |  |       |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |  |  |                      |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |  |       |  |  |  |
| 11. BIRTHPLACE (County & State or foreign country) <u>Massachusetts</u>   |  |  |  |                      |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |       |  |  |  |
| 13. FATHER'S NAME <u>Barnett Gerson</u>   |  |  |  |                      |  | 14. MOTHER'S MAIDEN NAME <u>Mollie Feldman</u>   |  |       |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  |  |  |                      |  | 16. SOCIAL SECURITY NO. <u>Unascertainable</u>   |  |       |  |  |  |
| 17. INFORMANT <u>The Medical Records</u>  |  |  |  |                      |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>271.0</u> DUE TO <u>Postoperative Cardiac Arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hyperparathyroidism</u><br><u>Neck and Media-stinal Exploration</u> |  |       |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |                      |  | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u><br><u>5 Years</u><br><u>30 Minutes</u>   |  |       |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |       |  |  |  |
| 20c. TIME OF INJURY <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>September 13, 19 61</u> 20f. (City or town) <u>September 25, 19 61</u> (County) <u>7:20pm</u> (State)                                   |  |  |  |                      |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |       |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>September 13, 19 61</u> to <u>September 25, 19 61</u> that (I) (we) last saw the deceased alive on <u>September 25, 19 61</u> and that death occurred at <u>7:20pm</u> from the causes and on the date stated above. |  |  |  |                      |  | 22a. SIGNATURE <u>John R. Gill, Jr.</u> M.D. 22b. ADDRESS <u>The Clinical Center National Institutes Of Health, Bethesda 14, Md.</u>   |  |       |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/28/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Progressive Cem.</u> 23d. LOCATION (City, town or county) <u>Everett, Mass.</u> (State)   |  |  |  |                      |  | 25a. REC'D BY REGISTRAR <u>SEP 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>  |  |       |  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VR A15 (A)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

**10454**

**10448**

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br>c. LENGTH OF STAY IN b.<br><u>11</u> Years<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>107 Gladwyne Court</u>                      |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br>d. STREET ADDRESS<br><u>107 Gladwyne Court</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>ERNST</u><br>5. SEX <u>Male</u><br>6. COLOR OR RACE <u>White</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | (None) <u>SCHWARZ</u><br>4. DATE OF DEATH <u>Sept. 23</u> 19 <u>61</u><br>8. AGE (In years last birthday) <u>71</u> yrs. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS. <input type="checkbox"/>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Zoologist</u><br>10b. KIND OF BUSINESS OR INDUSTRY<br><u>Gov't</u><br>11. BIRTHPLACE (County & State, or foreign country)<br><u>Frankfurt, Germany</u><br>12. CITIZEN OF WHAT COUNTRY?<br><u>U.S. Naturalized</u>                           |  | 13. FATHER'S NAME<br><u>Julius Schwarz</u><br>14. MOTHER'S MAIDEN NAME<br><u>Emily Nussbaum</u><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u><br>16. SOCIAL SECURITY NO.<br><u>\$19-44-4715</u><br>17. INFORMANT <u>Wife</u> Address <u>Same as item 2.</u>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>(b) <u>Renal Insufficiency</u><br>(c) <u>Chronic Pyelonephritis + Renal Atrophy</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Approx. 6 mon.</u><br><u>10 years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER).<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>22 Aug. 1961</u> to <u>23 Sept. 1961</u> , that (I) <u>(see)</u> last saw the deceased alive on <u>23 Sept. 1961</u> , and that death occurred at <u>8:28</u> M. from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><u>J.B. MacGregor</u><br>22c. PHYSICIAN'S NAME (Type)<br><u>J.B. MacGregor</u>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS<br><u>Washington Clinic, Washington, D.C.</u><br>22b. DATE SIGNED<br><u>9-23-61</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u><br>23b. DATE THEREOF<br><u>9-23-61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u><br>23d. LOCATION (City, town or county) (State)<br><u>Prince George Co., Md.</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>ROBERT A. PUMPHREY</u><br>ADDRESS<br><u>Bethesda, Md.</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 27 '61</u><br>25b. REGISTRAR'S SIGNATURE<br><u>O. L. H. H. H.</u>  |  |

MEDICAL CERTIFICATION

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10455

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

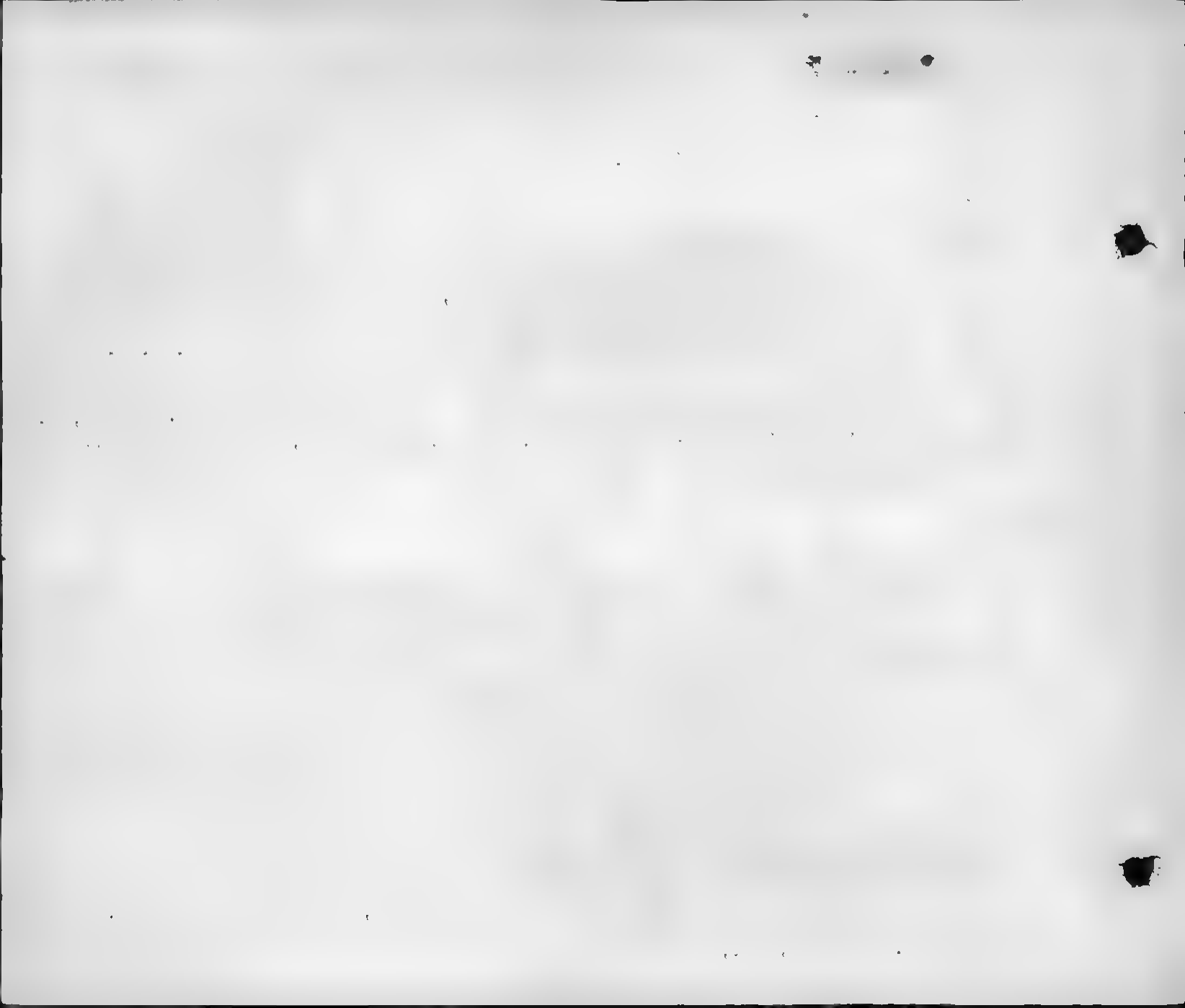
CERTIFICATE OF DEATH

Reg. Dist. No. 10449

|  |                           |  |   |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY MONTGOMERY MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)<br>a. STATE MARYLAND b. COUNTY MONTGOMERY                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 55  |   |
| c. LENGTH OF STAY IN 1b 12 yrs.  |                           | d. STREET ADDRESS 4525 RANDOLPH ROAD 1   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4525 RANDOLPH ROAD  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last FRITZ EMORY SCHWEIKERT   |                           | 4. DATE OF DEATH SEPTEMBER 26 1961   |   |
| 5. SEX MALE  | 6. COLOR OR RACE WHITE    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 6, 1897               |
| 9. AGE (In years last birthday) 64 yrs.  |                           | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo finisher (retired)   |                           | 10b. KIND OF BUSINESS OR INDUSTRY Developing & Printing  |   |
| 11. BIRTHPLACE (State or foreign country) North Carolina   |                           | 12. CITIZEN OF WHAT COUNTRY? U. S. A.  |   |
| 13. FATHER'S NAME LOUIS SCHWEIKERT   |                           | 14. MOTHER'S MAIDEN NAME CARRIE WILLIAMS   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW'S 1 & 2  |                           | 16. SOCIAL SECURITY NO. 577-36-3874  |   |
| 17. INFORMANT MRS. PARK O. SCHWEIKERT  |                           | Address (SILVER SPRING, MD.)   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart Failure.<br>5222 DUE TO Chronic Myocarditis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)          |                           | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from 1955, 19, to 9-26, 1961, that I last saw the deceased alive on 9-26, 1961, and that death occurred at 8:00 P. M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>Luciano J. Leal M.D. Gaithersburg, Md |                           |  |   |
| ACTUAL SIGNATURE   |                           |  |   |
| PHYSICIAN'S NAME (Type) Lucio L. Leal  |                           |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   | 22b. DATE THEREOF 9/29/61 | 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY, ARLINGTON COUNTY, VA.  | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.  |                           | 24a. REC'D BY REGISTRAR DATE SEP 29 '61  | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

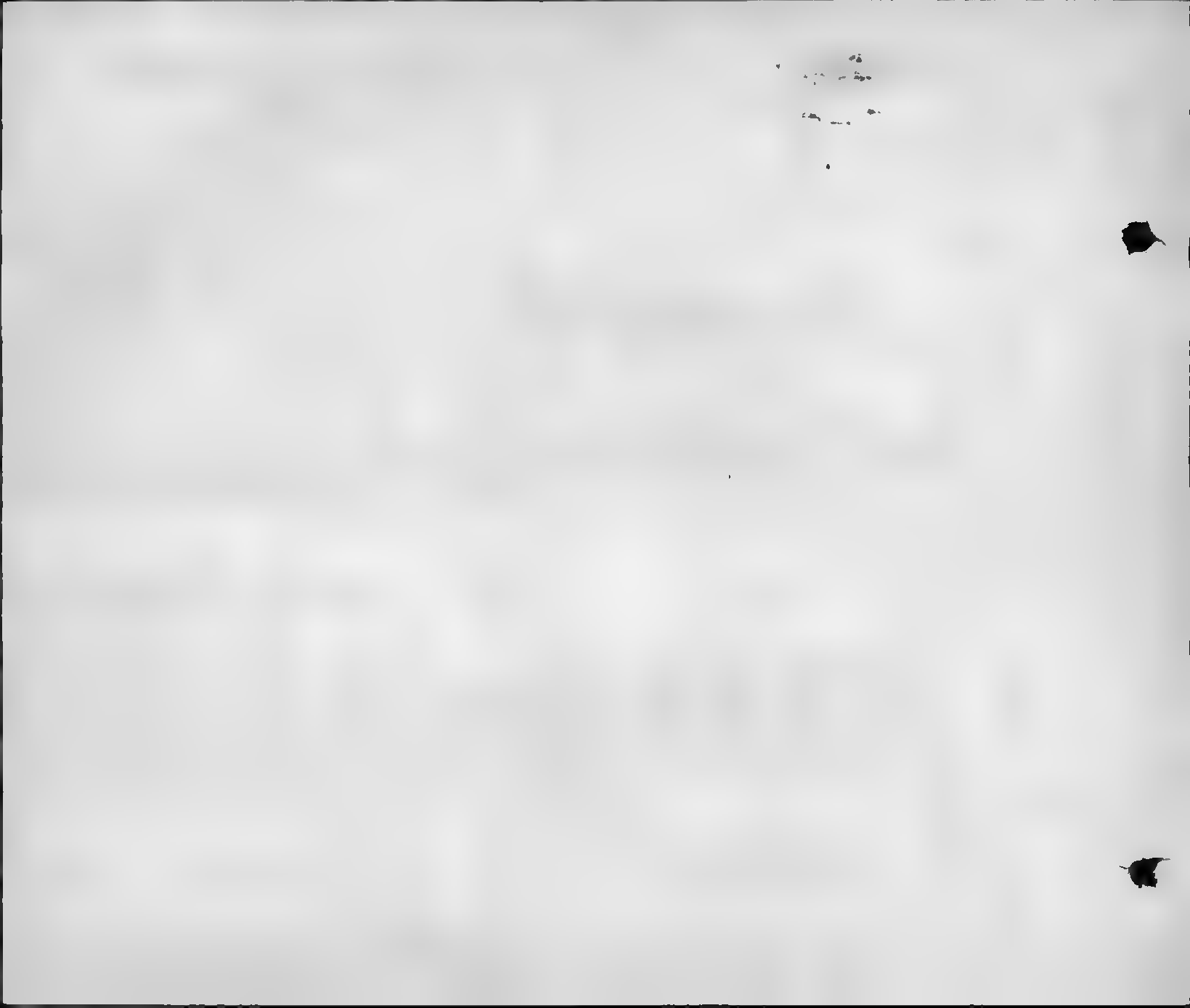
10456

10450

|   |                           |  |                                     |  |                 |  |                  |
|---|---------------------------|--|-------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                           |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>MONTG.</u> |                 |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>   |                           |  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>                                |                 |  |                  |
| c. LENGTH OF STAY IN 1b <u>8 yrs.</u>   |                           |  |                                     | d. STREET ADDRESS <u>700-BAYFIELD ST.</u>  |                 |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100-BAYFIELD ST.</u>  |                           |  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                 |  |                  |
| 3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>-</u> Last <u>SHAPIRO</u>   |                           |  |                                     | 4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1961</u>  |                 |  |                  |
| 5. SEX <u>m</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct-16-1893</u> | 9. AGE (In years last birthday) <u>67</u> yrs  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEERING</u>   |                                     | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>  |                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |                  |
| 13. FATHER'S NAME <u>UNKNOWN</u>  |                           |  |                                     | 14. MOTHER'S MAIDEN NAME <u>MOLLIE</u>   |                 |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <u>No</u>   |                           | 16. SOCIAL SECURITY NO. <u>578-24-8562</u>   |                                     | 17. INFORMANT <u>DR HARRY A. SHAPIRO</u>   |                 | Address <u>5713-BRADLEY BLVD</u>                                       |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                           |  |                                     |  |                 | INTERVAL BETWEEN ONSET AND DEATH                                       |                  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration</u> <u>Pneumonia</u>  |                           |  |                                     |  |                 | <u>3 days</u>  |                  |
| DUE TO (b) <u>Parkinson's</u> <u>Disease</u>  |                           |  |                                     |  |                 | <u>7 years</u>   |                  |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last <u>Cerebral</u> <u>Arteriosclerosis</u>   |                           |  |                                     |  |                 |  |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                     |  |                 |  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           |  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                       |                 |  |                  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                           |  |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                             |                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                  |
|   |                           |  |                                     | 20f. (City or town) (County) (State)   |                 |  |                  |
| 21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>9/2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/2</u> , 19 <u>61</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above. |                           |  |                                     |  |                 |  |                  |
| ACTUAL SIGNATURE <u>Irving W. Winik</u> M.D.  |                           |  |                                     | ADDRESS (Street, city or town, state) <u>3900 McKinley St. N.W.</u> DATE SIGNED <u>9/3/61</u>                                      |                 |  |                  |
| PHYSICIAN'S NAME (Type) <u>Irving W. Winik</u>  |                           |  |                                     | Washington, D.C.   |                 |  |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                           | 22b. DATE THEREOF <u>9/4/61</u>  |                                     | 22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L CAP. Heb. Cem.</u>   |                 | 22d. LOCATION (City, town, or county) (State) <u>DC</u>                |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Deleberg Funeral Home</u>   |                           |  |                                     | ADDRESS <u>4217-9<sup>th</sup> St.</u>   |                 | 24a. REC'D BY REGISTRAR <u>P 6 '61</u>                                 |                  |
|   |                           |  |                                     | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |                 |  |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

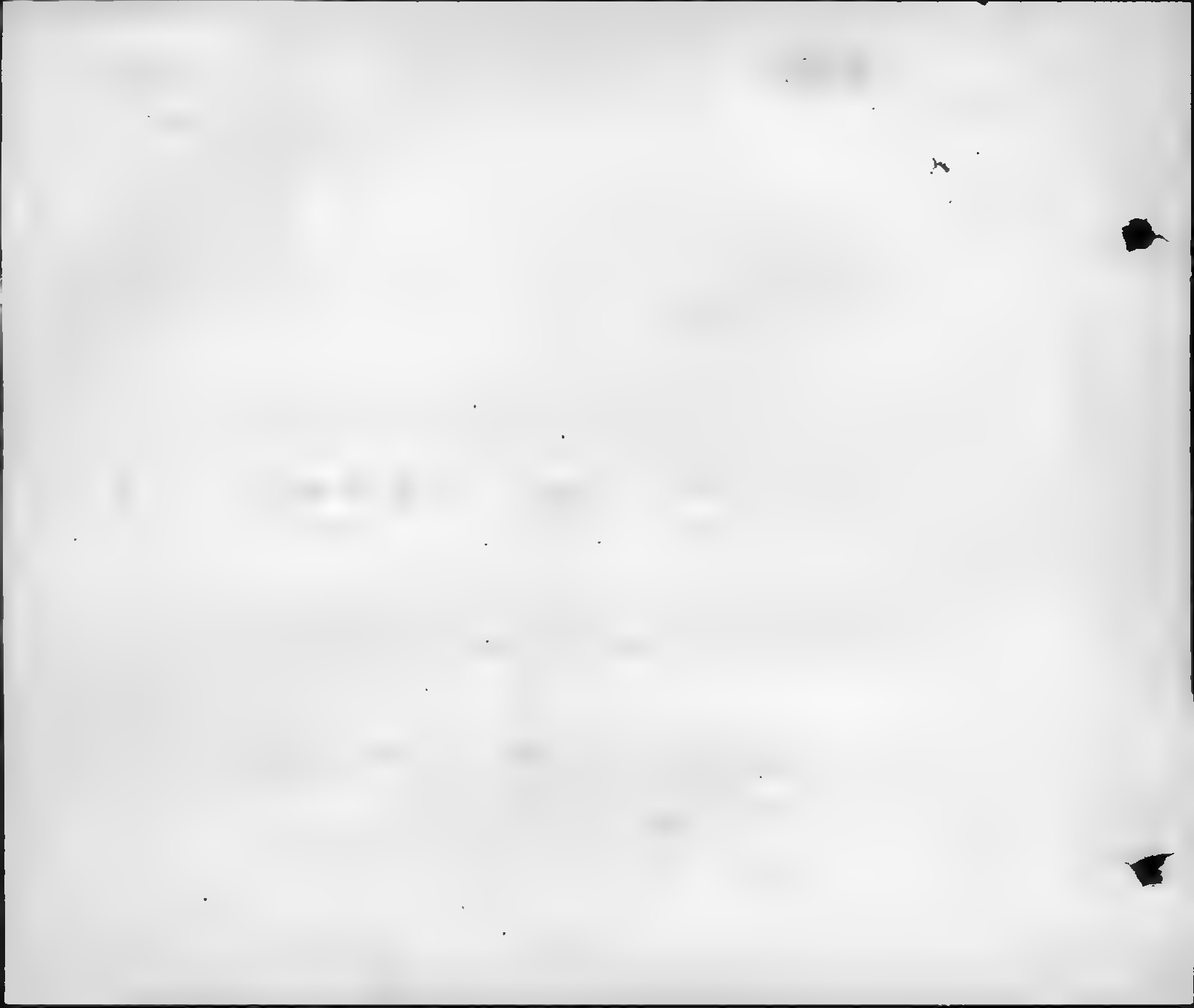
## CERTIFICATE OF DEATH

10457

Items 7, 8 &amp; 12 Film G-95 9/14/61 ink

10451

|   |                            |  |                                   |
|---|----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                            | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>             |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>   |                            | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San &amp; Hosp</u>   |                            | d. STREET ADDRESS <u>801 FORREST GLEN Rd</u>   |                                   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Flora</u> Middle <u>Shattuck</u> Last <u>Shattuck</u>   |                            | 4. DATE OF DEATH <u>Sept 8</u> 19 <u>61</u>  |                                   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>wh</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-4-1895</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs   |                            | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>  |                            | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>NOVA SCOTIA</u>  |                            | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> <input checked="" type="checkbox"/>   |                                   |
| 13. FATHER'S NAME <u>Cavey SHATFORD</u>   |                            | 14. MOTHER'S MAIDEN NAME <u>Bridgett DUGGAN</u>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)  |                            | 16. SOCIAL SECURITY NO.  |                                   |
| 17. INFORMANT <u>PHYLLIS S. STONE</u>   |                            | Address <u>801 FORREST GLEN Rd</u>   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>4701 DUE TO<br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arterio Sclerotic Vascular Disease</u><br>DUE TO<br>(c) |                            | INTERVAL BETWEEN ONSET AND DEATH <u>73 min</u>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac insufficiency with ascites</u>   |                            | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                            | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)   |                            | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1961</u> , to <u>Sept 8, 1961</u> , that (I) (we) lost saw the deceased alive on <u>Sept 8, 1961</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above  |                            |  |                                   |
| 22a. SIGNATURE <u>Chas. Rogers</u> M.D.   |                            | 22b. DATE SIGNED <u>Sept 5, 1961</u>   |                                   |
| 22c. PHYSICIAN'S NAME (Type)  |                            | 22d. ADDRESS <u>1919 Democracy Rd. Silver Spring, Md.</u>  |                                   |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>   |                            | 23b. DATE THEREOF <u>9/11/61</u>   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>   |                            | 23d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>  |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>   |                            | 25a. REC'D BY REGISTRAR <u>SEP 11 '61</u>  |                                   |
| ADDRESS <u>4812 GEORGIA AVE WASHINGTON, D.C.</u>  |                            | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>   |                                   |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10458

10452

|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b>   |  | c. LENGTH OF STAY IN MD<br><b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Montgomery</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b> |  | d. STREET ADDRESS<br><b>3905 Harvard Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Cecilia</b>  |  | 4. DATE OF DEATH<br><b>Sept. 14</b>  |  | 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 23, 1884</b>  |  | 9. AGE (In years, if over 1 year; last birthday)<br><b>76</b> yrs. <b>11</b> months <b>21</b> days |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>Thomas F. Higgins</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret E. Dublin</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                    |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>John W. Sherman-son-same 2d</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b><br>(a), stating the underlying cause last. (c) <b>420.1</b><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b> |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                             |  | 20f. (City or town)<br><b>September</b>  |  | 20g. (County)<br><b>September</b>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12 July, 1961</b> , to <b>14 July, 1961</b> , that (I) (we) last saw the deceased alive on <b>12 July, 1961</b> , and that death occurred at <b>14 July, 1961</b> , from the cause and on the date stated above. |  | 22a. SIGNATURE<br><b>George H. Mitchell</b>  |  | 22b. DATE SIGNED<br><b>14 September 61</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>George H. Mitchell M.D.</b>   |  | 22d. ADDRESS<br><b>10620 Georgia Avenue, Silver Spring, Md</b>   |  | 22e. ATTENDING PHYS.<br><input checked="" type="checkbox"/>  |  | 22f. MED. DIRECTOR<br><input type="checkbox"/>   |  | 22g. STAFF PHYS.<br><input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>9/16/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John Cemetery</b>                               |  | 23d. LOCATION (City, town or county)<br><b>Geistown, Pennsylvania</b>  |  | 23e. REC'D BY REGISTRAR<br><b>SEP 18 '61</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>   |  | 23g. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>                                     |  | 23h. ADDRESS<br><b>Bethesda, Maryland</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2-1-23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

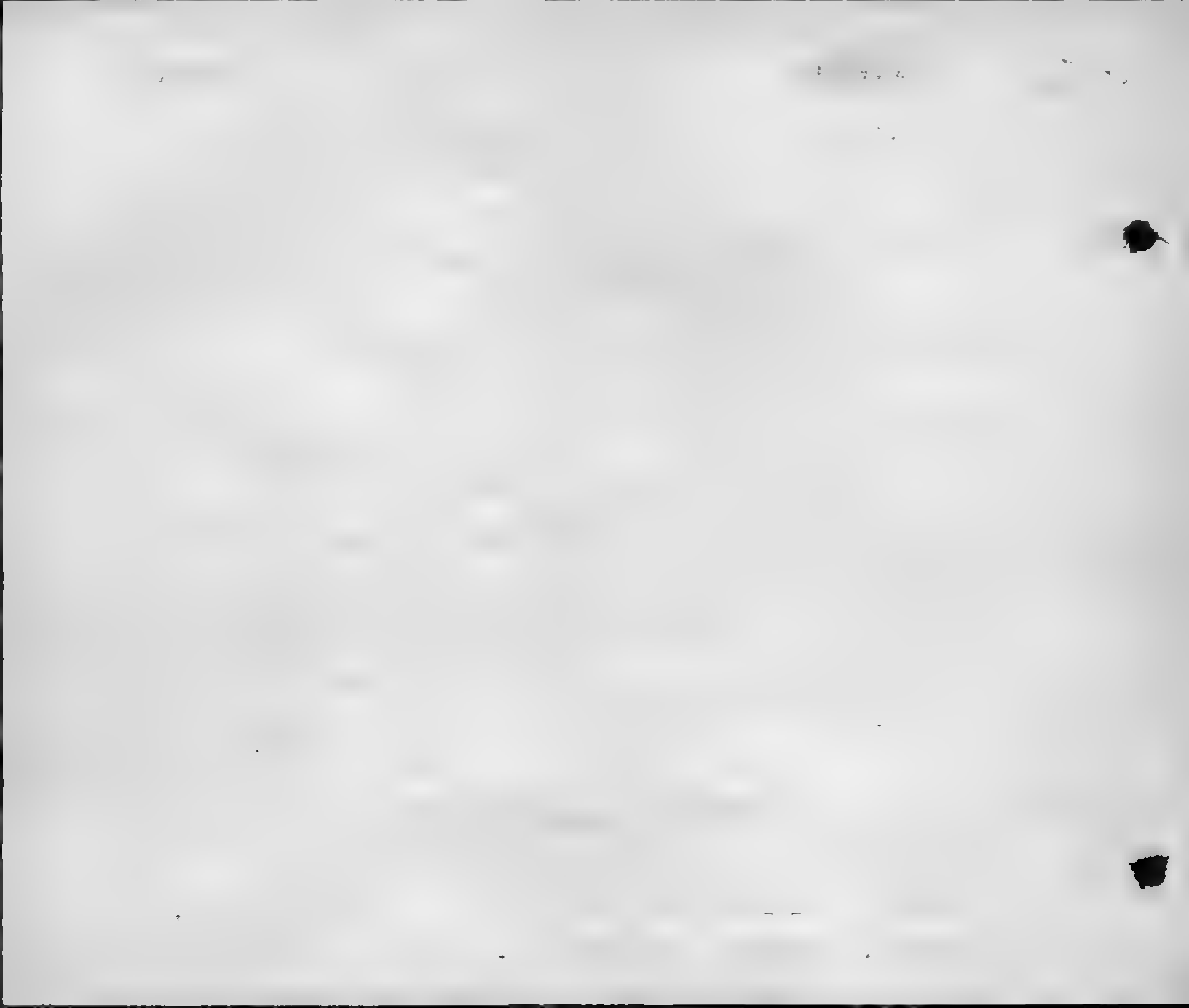
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10459

## CERTIFICATE OF DEATH

10453

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Rural (Bethesda)</u><br>c. LENGTH OF STAY IN 1b <u>1 month</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmore Nursing Home</u>  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Indiana</u> b. COUNTY <u>Lake</u><br>c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Gary</u><br>d. STREET ADDRESS <u>918 E 6th Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Mildred Marie Simon</u>  |  |  | <b>4. DATE OF DEATH</b><br><u>Sept. 3 1961</u>  |  |  |
| <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>  |  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>August 18, 1880</u><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>   |  |  | <b>9. AGE</b> (In years last birthday) <u>81 yrs.</u> <b>IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>1</u> <b>IF UNDER 24 HRS.</b> Hours <u>5</u> Min. <u>0</u>   |  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Michigan</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |  | <b>13. FATHER'S NAME</b> <u>Charles Comstock</u><br><b>14. MOTHER'S M.A.DEN NAME</b> <u>Catherine O'Leary</u>   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown, (If yes give war or dates of service)) <u>no</u><br><b>16. SOCIAL SECURITY NO.</b> <u>no</u><br><b>17. INFORMANT</b> <u>Mrs. Jack Linder (daughter)</u> Address <u>9005 Burning Tree Rd. Bethesda</u>  |  |  | <b>18. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia, Hypostatic</u><br>DUE TO (b) <u>Cerebral thrombosis, (arteriosclerosis)</u><br>DUE TO (c) <u>Diabetes mellitus, Known 3 months</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 days</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II. of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>9/2</u> p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> <u>at work</u> <input type="checkbox"/> <u>Not at work</u> <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> <u>Bethesda</u> (County) <u>Calvary</u> (State) <u>Md.</u> |  |  | <b>19. WAS A AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from 7/4 1961 to 9/2 1961, that (I) (we) last saw the deceased alive on 9/2 1961, and that death occurred at 10 A.M. from the causes and on the date stated above.</b>  |  |  |   |  |  |
| <b>22a. SIGNATURE</b> <u>Allen J. O'Neill MD</u><br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>Allen J. O'Neill MD</u>  |  |  | <b>22b. DATE SIGNED</b> <u>SEP 7 '61</u><br><b>22d. ADDRESS</b> <u>8601 Old Georgetown Rd. Bethesda Md</u>  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit 9-4-61</u><br><b>23b. DATE THEREOF</b> <u>9-4-61</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Calvary Cemetery</u><br><b>23d. LOCATION</b> (City, town or county) <u>Berrien County, Indiana</u> (State) <u>Indiana</u>   |  |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u><br><b>25a. REC'D BY REGISTRAR</b> <u>SEP 7 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>William L. Kraus</u>   |  |  |



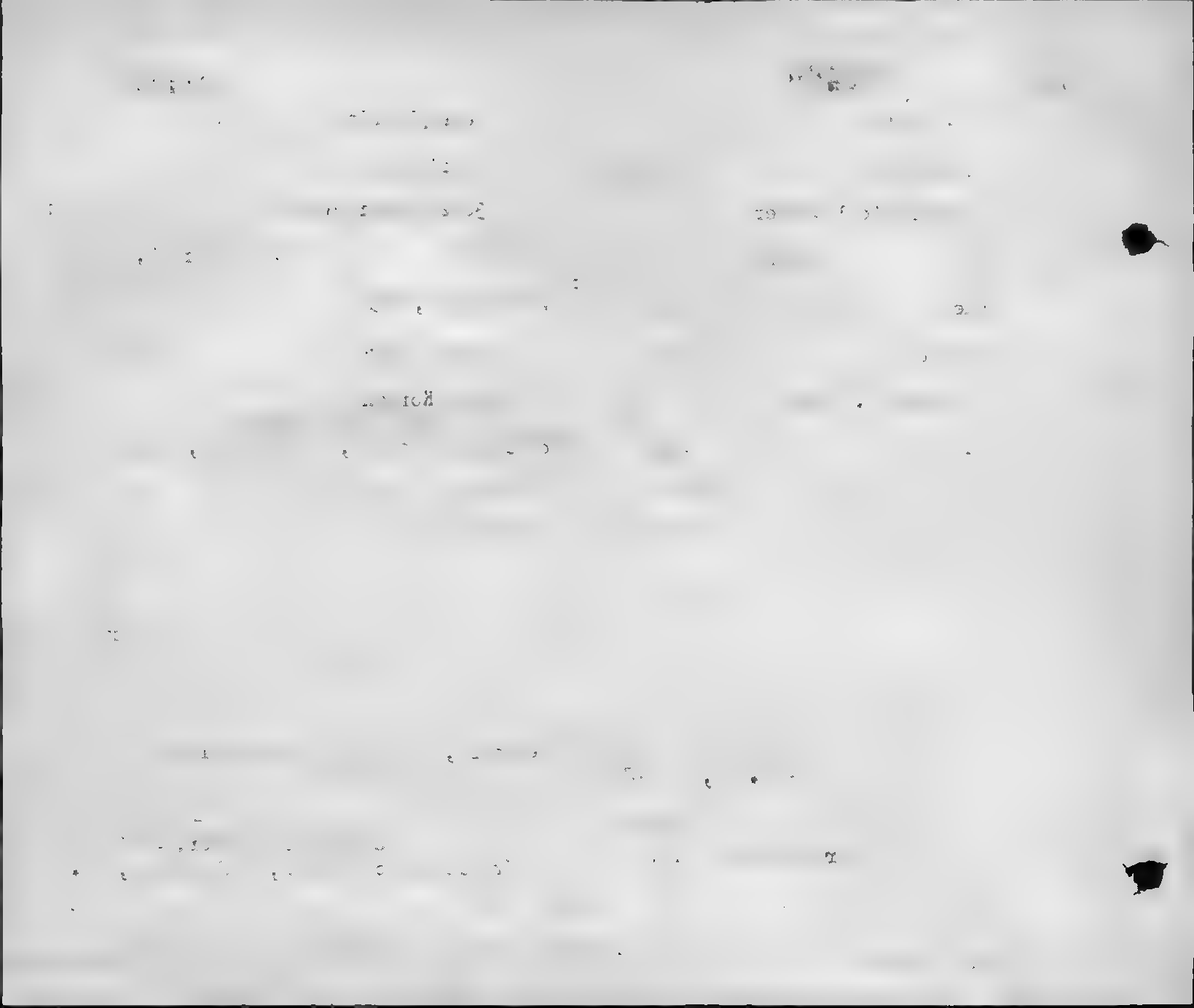
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY (In days) <b>93 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center</b> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, state where before admission)<br>a. STATE <b>Pennsylvania</b><br>b. COUNTY <b>Dauphin</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harrisburg</b><br>d. STREET ADDRESS <b>3612 Kramer Street</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>KORMAN</b> Last <b>SKELLY</b>  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>15</b> Year <b>1961</b>   |  |
| 5. SEX <b>Male</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>November 28, 1956</b><br>9. AGE (In years, last birthday) <b>4</b> yrs. IF UNDER 1 YEAR: Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min. IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>None</b><br>11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b><br>12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                               |  | 13. FATHER'S NAME <b>William C. Skelly</b><br>14. MOTHER'S MAIDEN NAME <b>Marian Korman</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b><br>16. SOCIAL SECURITY NO. <b>None</b><br>17. INFORMANT <b>The Medical Record</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Increased intracranial pressure</b><br>DUE TO (b) <b>metastatic neuroblastoma</b><br>DUE TO (c) <b>metastatic neuroblastoma</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |
| 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/><br>INTERVAL BETWEEN ONSET AND DEATH <b>2 months 9 months</b>   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.<br>20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 14, 1961</b> to <b>September 15, 1961</b> that (I) (we) last saw the deceased alive on <b>Sept. 15, 1961</b> , and that death occurred <b>1:05 PM</b> from the causes and on the date stated above.                                 |  |   |  |
| 22a. SIGNATURE <b>Marvin Lewis</b><br>22c. PHYSICIAN'S NAME (Type) <b>Marvin Lewis M.D.</b>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>9-15-61</b><br>22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b><br>23b. DATE THEREOF <b>9-18-61</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>East Harrisburg Pa.</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Harrisburg, Dauphin Co. Pa.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>George M. Hetrick</b><br>ADDRESS <b>3125 Walnut St. Harrisburg</b>  |  | 25a. REC'D BY REGISTRAR <b>SEP 18 '61</b><br>25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>  |  |



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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10461 10454

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville  
c. LENGTH OF STAY IN 1b D.O.A.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Monty General Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)  
a. STATE md b. COUNTY mntg  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring  
d. STREET ADDRESS Chandler Mill Rd 1

3. NAME OF DECEASED (Type or print) Vickey Lynn Slusher  
First Middle Last  
4. DATE OF DEATH Sept 9 1961  
Month Day Year

5. SEX Female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 7-28-61  
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years, last birthday) 11 yrs. IF UNDER 1 YEAR: Months 1 Days 11 Hours  Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 10b. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (State or foreign country) md 12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME Dallas Slusher 14. MOTHER'S MAIDEN NAME Charles Gabriel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Charles Slusher (mother) Address Stm 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Asphyxia DUE TO upper Resp Infection  
Conditions, if any, which gave rise to immediate cause (b)   
(c)   
DUE TO   
cause listed.   
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town)  County  (State)

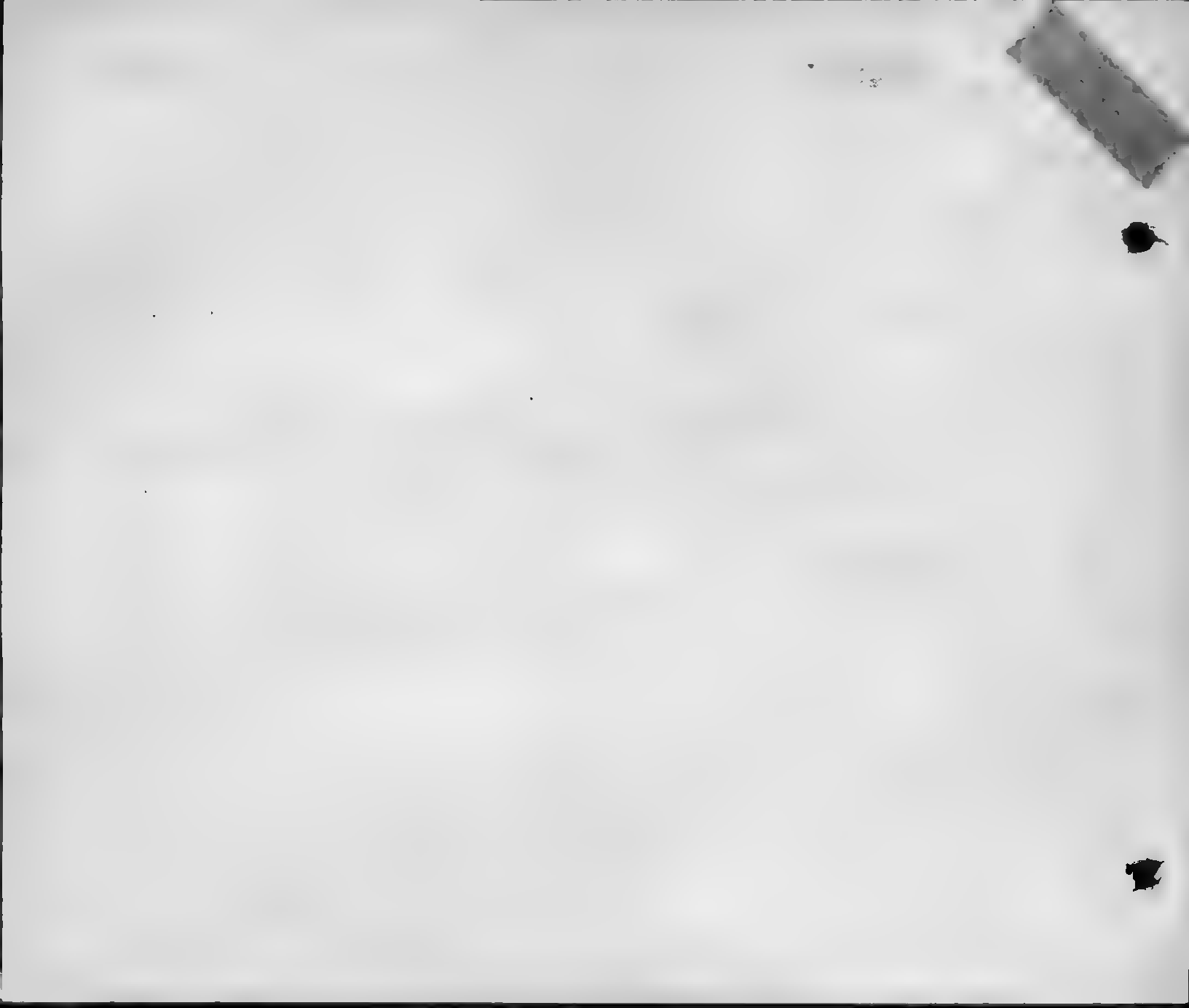
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) FRANK J. Broschant ASS STANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 9-9-61  
Address (Street, city, town or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/11/61 22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery 22d. LOCATION (City, town, or country) (State) Gaithersburg, Maryland

23. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland 24a. REC'D BY REG. STRAR SEP 14 '61 24b. REGISTRAR'S SIGNATURE William S. Hume

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10462

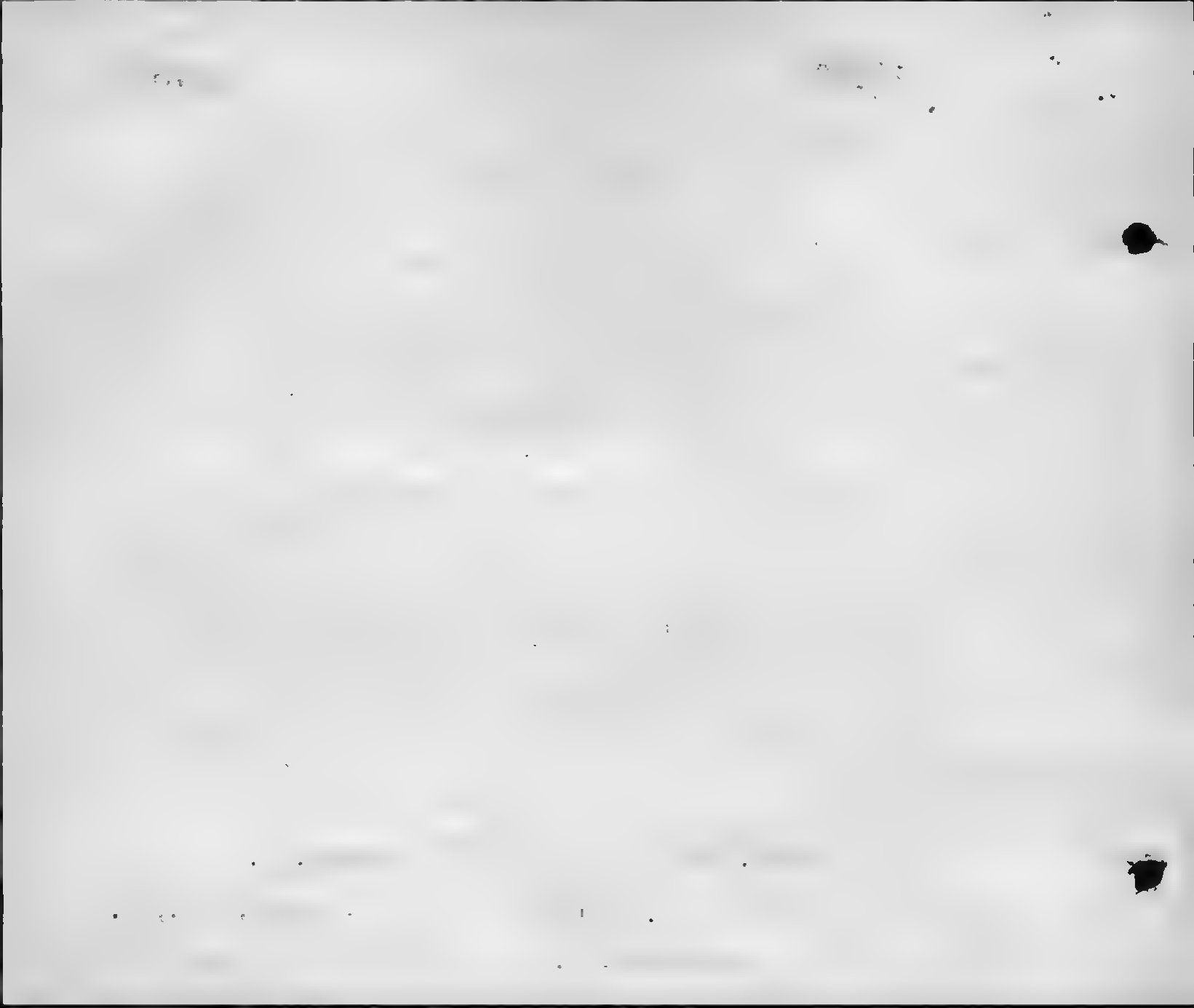
10456

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>c. LENGTH OF STAY IN Bldg. <u>1 hrs. &amp; 15 min</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Luke's</u> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>a. STATE <u>MD.</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>d. STREET ADDRESS <u>14150 Travilah Rd</u> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Gorothy Connelly Smith</u>   |  | DATE OF DEATH <u>Sept. 26 1961</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>                  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>9/12/20</u>  |
| 9. AGE (In years last birthday) <u>41</u>  |  | 10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Wallace W. Connelly</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Willie Mills</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war dates of service) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>  </u>   |  |
| 17. INFORMANT <u>Ralph U. Smith</u>  |  | Address <u>As above</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>  |  |   |  |
| 491X DUE TO  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u>   |  |   |  |
| DUE TO (c) <u>  </u>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right pneumonectomy and Thoracoplasty</u>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 1)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. <u>  </u> p.m. <u>  </u>  | Month, Day, Year <u>  </u> <u>  </u> <u>  </u> | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u> |
| 20f. (City or town) <u>  </u>  |  | (County) <u>  </u> (State) <u>  </u>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 3, 1952</u> to <u>9/26/61</u> , that (I) (we) last saw the deceased alive on <u>7/24/61</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE <u>Stephen N. Jones</u>   |  | 22b. DATE SIGNED <u>9/27/61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>   |  | 22d. ADDRESS <u>Rockville, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>9/30/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>   |  | 23d. LOCATION (City, town or county) <u>Nr. Redland, Mont., Md.</u>   |  |
| 23e. ADDRESS <u>Laytonsville, Md.</u>  |  | 23f. (State) <u>  </u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>  |  | 25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Carlton L. Harris</u>   |  |
| DATE <u>SEP 29 1961</u>  |  | DATE <u>  </u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

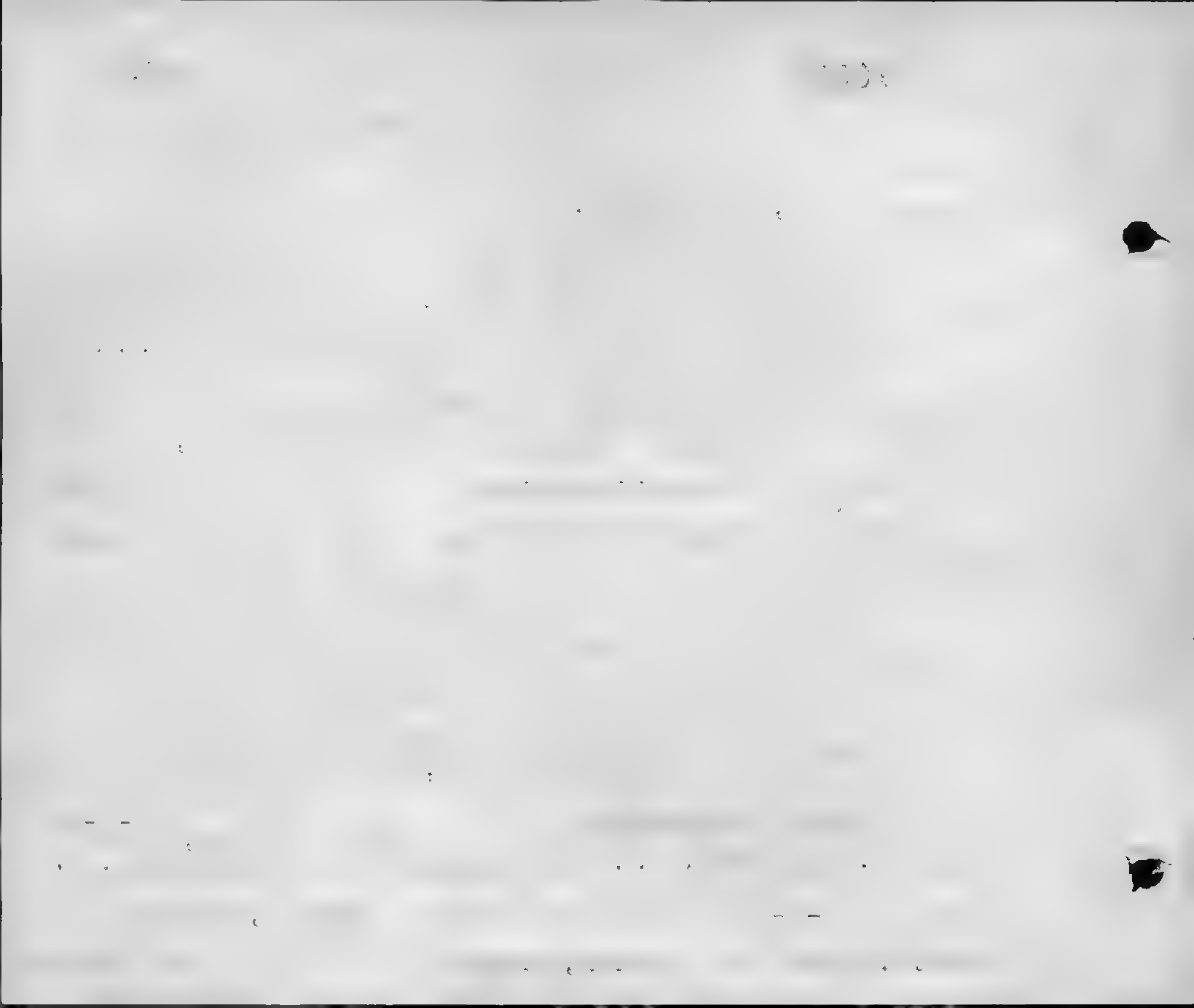
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10463

10457

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>5 Days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u> |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u><br>d. STREET ADDRESS <u>No Street address</u>                   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Gregory Michael Smith</u>  |                               | 4. DATE OF DEATH <u>September 25, 19 61</u>   |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>January 6, 1952</u> |
| 9. AGE (In years, last birthday) <u>9 yrs.</u>   |                               | 10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>9</u> Hours <u>9</u> Mins. <u>9</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   |   |
| 11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>Charles Smith</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Nancy Moore</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u>None</u>   |   |
| 17. INFORMANT <u>The Medical Records</u>   |                               | 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>(a) <u>Intracranial Hemorrhage</u><br>(b) <u>Acute Lymphocytic Leukemia</u><br>(c) <u>1043</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               | INTERVAL BETWEEN ONSET AND DEATH <u>48 Hours</u><br><u>2 Weeks</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <u>he</u> (this hospital) attended the deceased from <u>September 25, 19 61</u> to <u>September 25, 19 61</u> , that (I) (we) last saw the deceased alive on <u>September 25, 19 61</u> , and that death occurred <u>5:20 p.m.</u> from the causes and on the date stated above.                        |                               |   |   |
| 22a. SIGNATURE <u>J. David Heywood</u> M.D.  |                               | 22b. DATE SIGNED <u>9-26-61</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>J. DAVID HEYWOOD, M.D.</u>   |                               | 22d. ADDRESS <u>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>9-28-1961</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>  |                               | 23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey &amp; Son</u>   |                               | 25a. REC'D BY REGISTRAR <u>SEP 29 '61</u>   |   |
| ADDRESS <u>Frederick, Maryland</u>   |                               | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>  |   |



1  
FOR STATE  
HEALTH DEPT.

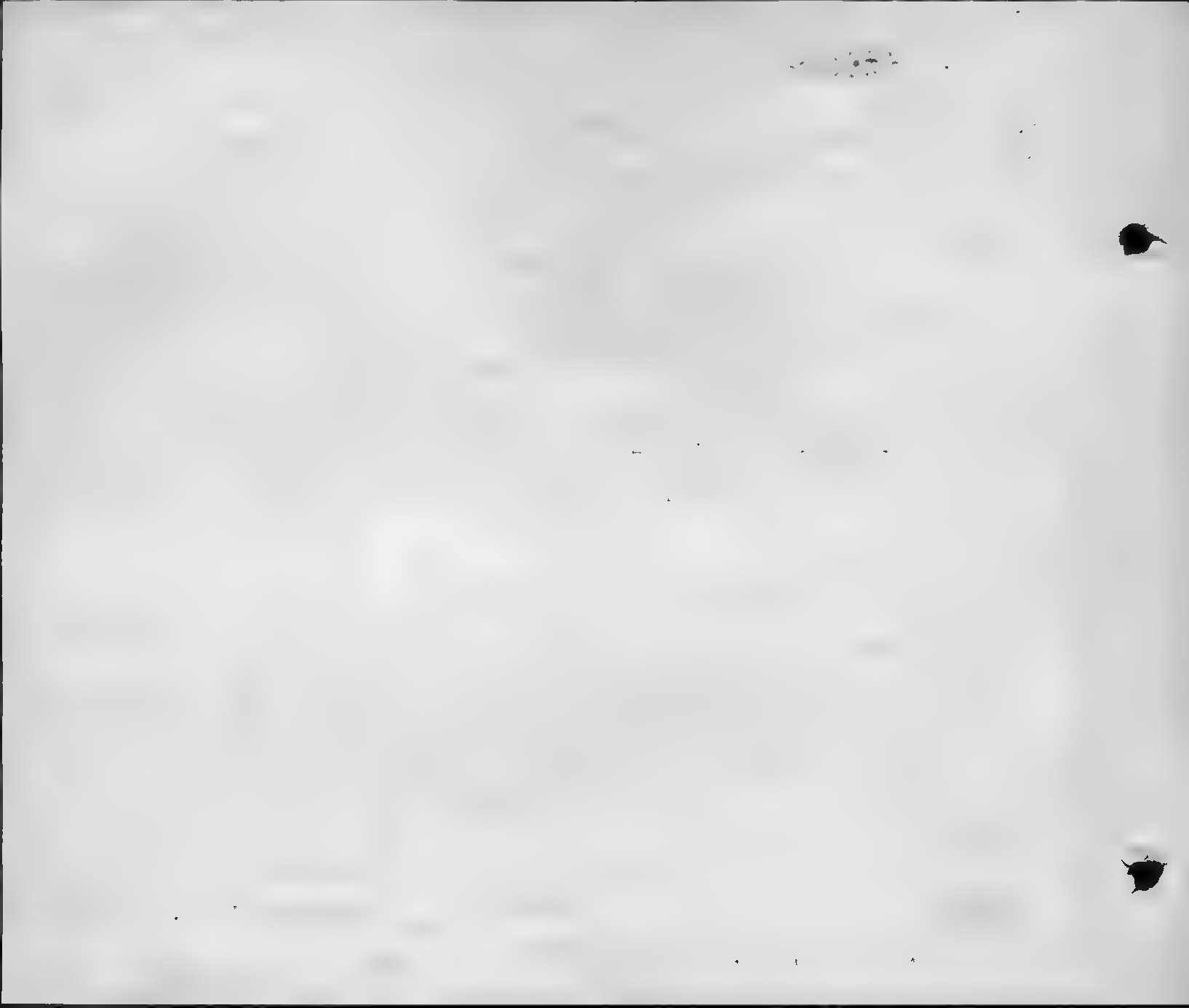
THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15ME  
5M 9/60

STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**10464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10458

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>montg</u>                       |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |
| c. LENGTH OF STAY IN 1b <u>15 mo.</u>  |  | d. STREET ADDRESS <u>17520 maple ave - apt 708</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7520 maple ave, apt 708</u>  |  | e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <u>John Robert Southerland</u>   |  | 4. DATE OF DEATH <u>Sept 17 1961</u>   |  |
| 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>11-21-1902</u>   |  | 9. AGE (in years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>9</u> Days <u>27</u> Hours <u></u> Min. <u></u>                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale groceries</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>S.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>James D. Southerland</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Mary Wells</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>577-03-9108</u>   |  |
| 17. INFORMANT <u>Marie Southerland (wife)</u> Address <u>Itasca 2</u>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemorrhage</u><br>DUE TO (b) <u>Rupture of aortic aneurysm</u><br>DUE TO (c) <u></u>  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden 3 pm.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>   |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>9/20/61</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>   |  | 22d. LOCATION (City, town, or country) (State) <u>Prince George's Co. Maryland</u>   |  |
| 23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>   |  | 24a. REC'D BY REGISTRAR <u>SEP 20 1961</u>   |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>   |  |  |  |



## CERTIFICATE OF DEATH

Reg. Dist. No. 10459

10465

|   |                                  |   |                                     |  |   |   |  |
|---|----------------------------------|---|-------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery County</b> MARYLAND  |                                  |   |                                     | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |                                  |   |                                     | c. LENGTH OF STAY IN 1b<br><b>?</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1125 Tanley Road</b>   |                                  |   |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Mary Elizabeth Spiker</b>   |                                  |   |                                     | 4. DATE OF DEATH Month Day Year<br><b>Sept. 22, 1961</b>   |   |   |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/7/1882</b> | 9. AGE (In years last birthday) yrs.<br><b>79</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Front Royal, Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                       |  |
| 13. FATHER'S NAME<br><b>James Gearing</b>   |                                  |   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Mary Catherine Shiner</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>none</b>   |                                     | INFORMANT Address<br><b>Carl G. Spiker -1125 Tanley Rd. Silver Spring</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last<br>DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (c) <b>Diabetes Mellitus</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis</b> |                                  |   |                                     |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>20 yrs</b><br><b>10 years</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                                     |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Jan 23, 1958</b> , to <b>Sept 22, 1961</b> , that I last saw the deceased alive on <b>Sept 22, 1961</b> , and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above.  |                                  |   |                                     |  |   |   |  |
| ACTUAL SIGNATURE <b>George B. Patrick Jr.</b> M.D.  |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>9221 Colesville Rd. 9/22/61</b>   |                                     |  |   |   |  |
| PHYSICIAN'S NAME (Type)<br><b>George B. Patrick, Jr. M.D.</b>   |                                  | <b>Silver Spring, Md.</b>   |                                     |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>9/26/61</b>   |                                     | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hebron Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Winchester, Va.</b>               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>The S. H. Hines Company Washington, D. C.</b>  |                                  |   |                                     | 24a. REC'D BY REGISTRAR<br><b>SEP 25 '61</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

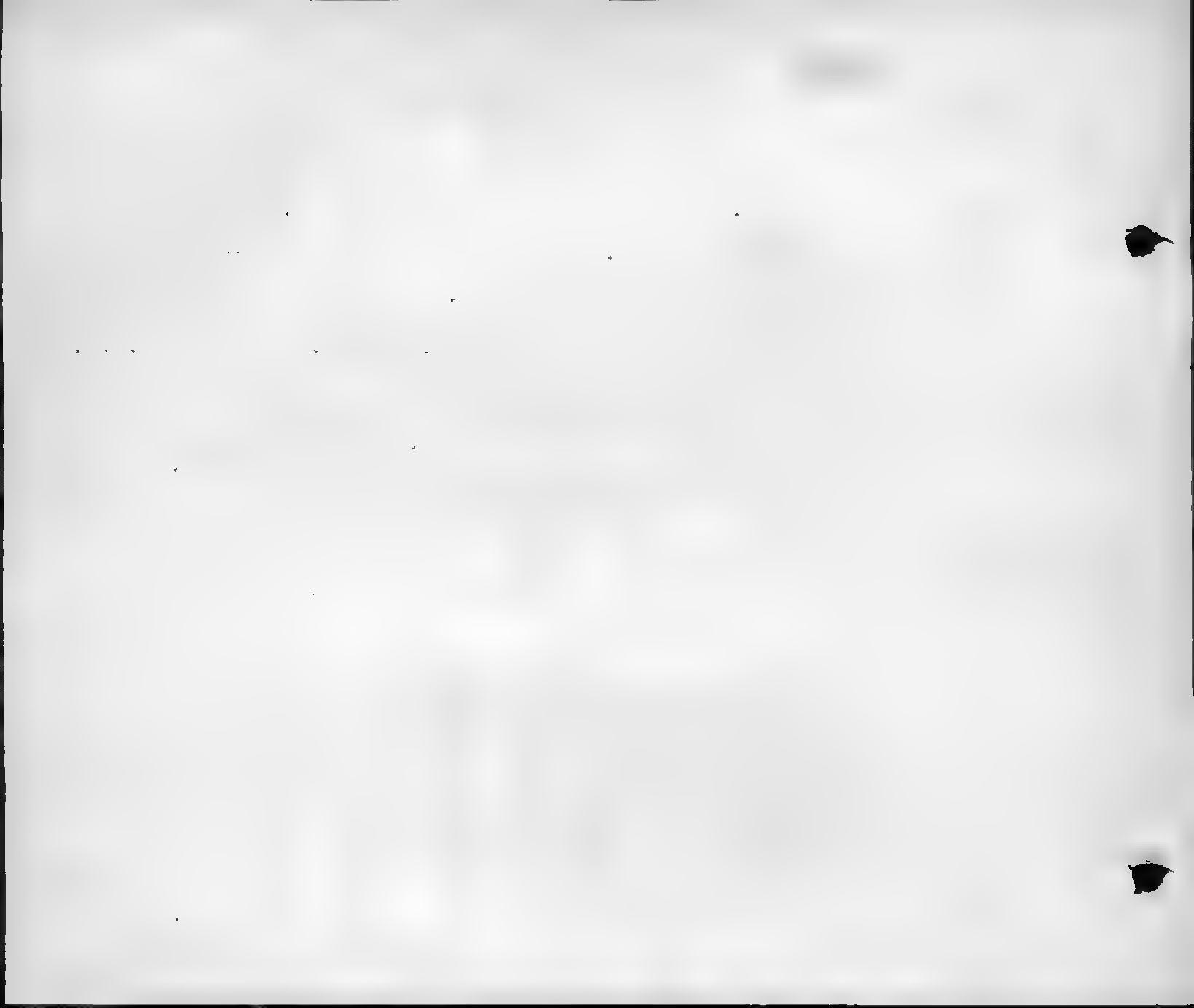
11669

10466

|   |                                  |  |                                       |  |  |  |  |
|---|----------------------------------|--|---------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)<br>STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  |  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> 56                                     |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4852 Western Ave.,</b>   |                                  |  |                                       | d. STREET ADDRESS<br><b>4852 Western Ave.,</b> 1   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                       |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>May</b> Middle <b>B.</b> Last <b>Stratton</b>   |                                  | 4. DATE OF DEATH<br>Month <b>9-</b> Day <b>24-</b> Year <b>1961</b>  |                                       |  |  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>12-23-1877</b> | 9. AGE (In years last birthday)<br><b>83</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min | IF UNDER 24 HRS<br>Months Days Hours Min                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - -</b>  |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Dist. of Col.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                  |  |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>- - -</b>  |                                       | 17. INFORMANT<br><b>Leonard S. Stratton, 4852 Western Ave</b>  |  |  |  |
|   |                                  |  |                                       | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO<br>(c) <b>Generalized Atherosclerosis + hypertension</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b><br><b>2 months</b><br><b>15 yrs.</b> |                                  |  |                                       |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                       |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |                                       |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |  |                                       |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> to <b>9/24</b> 19 <b>61</b> , that (I) <del>was</del> last saw the deceased alive on <b>9/23</b> 19 <b>61</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.  |                                  |  |                                       |  |  |  |  |
| 22a. SIGNATURE<br><i>[Signature]</i>  |                                  |  |                                       | 22b. DATE SIGNED<br><b>10/6/61</b>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>S. A. Thomas M.D.</b>  |                                  |  |                                       | 22d. ADDRESS<br><b>4301 48th St. NW. Washington D.C.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>9-24-1961</b>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Clonewood Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Cawley, Inc. 1756-Pa. Ave. N.W.</b>   |                                  |  |                                       |  |  |  |  |
| 25a. REC'D BY REGISTRAR<br><b>OCT 9 '61</b>   |                                  |  |                                       | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

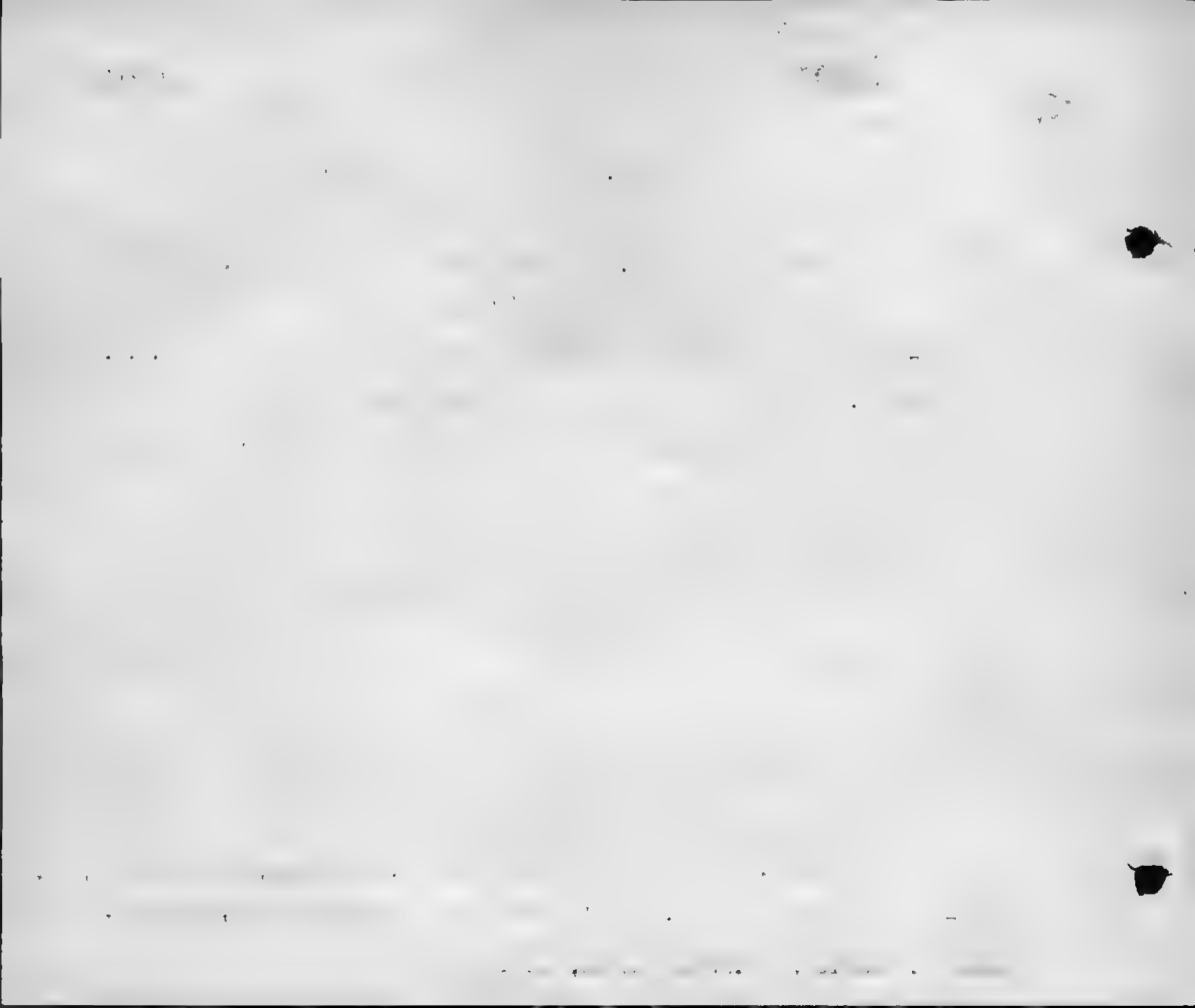
## CERTIFICATE OF DEATH

10467

10460

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN ILL <u>14 hrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutional residence, before admission)<br>a. STATE <u>Maryland</u> <span style="float: right;">MONTGOMERY</span><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>641 Sligo Avenue</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Timothy F. Sullivan</u><br>5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/14/1895</u><br>9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u>66</u> Days <u>22</u> Hours <u>19</u> Min <u>61</u>   |  | <b>4. DATE OF DEATH</b><br><u>Sept. 22 1961</u><br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Deck Hand</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>New York</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>James J. Sullivan</u><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW I</u><br>16. SOCIAL SECURITY NO. <u>None</u><br>17. INFORMANT <u>Margaret Sullivan (daughter)</u> Address <u>same as above</u>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u><br>(b) <u>mitral valve insufficiency (rheumatic?)</u><br>(c) <u>?</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Atherosclerosis</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/><br><b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Aspirin overdose</u><br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u><br><b>20f. (City or town)</b> <u>Silver Spring</u> <b>(County)</b> <u>Montgomery</u> <b>(State)</b> <u>Md.</u> |  | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 19 to Sept. 22, 1961</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>9/21 1961</u> , and that death occurred <u>7:30 AM</u> from the causes and on the date stated above.<br><b>22a. SIGNATURE</b> <u>William D. Aud</u> <b>22b. DATE SIGNED</b> <u>9/22/61</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>WILLIAM D. AUD</u> <b>22d. ADDRESS</b> <u>9006 Colesville Road, Silver Spring, Md.</u> |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-Tansit</u><br><b>23b. DATE THEREOF</b> <u>9/26/61</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peter's Cemetery</u><br><b>23d. LOCATION (City, town or county)</b> <u>Staten Island, New York.</u>  |  | <b>25a. REC'D BY REGISTRAR</b> <u>DATE SEP 26 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Items 18-21 Film 295 10468 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10461

FOR STATE HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u><br>c. LENGTH OF STAY IN 1b <u>9 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Hyattsville</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u><br>d. STREET ADDRESS <u>2000 Freedom Dr.</u> |  |  |
| 3. NAME OF DECEASED (Type or print) <u>MARIE</u>  |  |   | 4. DATE OF DEATH <u>Sept 8 1961</u>   |  |  |
| 5. SEX <u>Female</u>  |  |   | 6. COLOR OR RACE <u>white</u>   |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  |   | 8. DATE OF BIRTH <u>3-8-22</u>  |  |  |
| 9. AGE (In years last birthday) <u>39</u> yrs.  |  |   | 10. IF UNDER 1 YEAR Months Days Hours Min.  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u>  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u>  |  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |
| 13. FATHER'S NAME <u>G. P. Allen</u>  |  |   | 14. MOTHER'S MAIDEN NAME <u>Beatrice Sisco</u>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  |   | 16. SOCIAL SECURITY NO. <u>-</u>  |  |  |
| 17. INFORMANT <u>Wash San &amp; Hosp Chart</u>  |  |   | Address   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u><br>(b) <u>Broncho-pneumonia</u><br>(c) <u>Pulmonary embolism</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell in bathroom at home.</u>  |  |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |   |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathroom at home.</u>   |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>5:45 AMX 8-31 1961</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> |  |
| 20f. (City or town) <u>Hyattsville</u>  |  | 20g. (County) <u>P.G.</u>   |   | 20h. (State) <u>Md.</u>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |  |  |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u>   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>   |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |   | 22b. DATE THEREOF <u>9/11/61</u>  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>   |  |   | 22d. LOCATION (City, town, or country) (State) <u>Colmar Manor, Md</u>  |  |  |
| 23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>   |  |   | 24a. REC'D BY REGISTRAR <u>SEP 13 '61</u>   |  |  |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>  |  |   | DATE SIGNED <u>9-8-61</u>   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

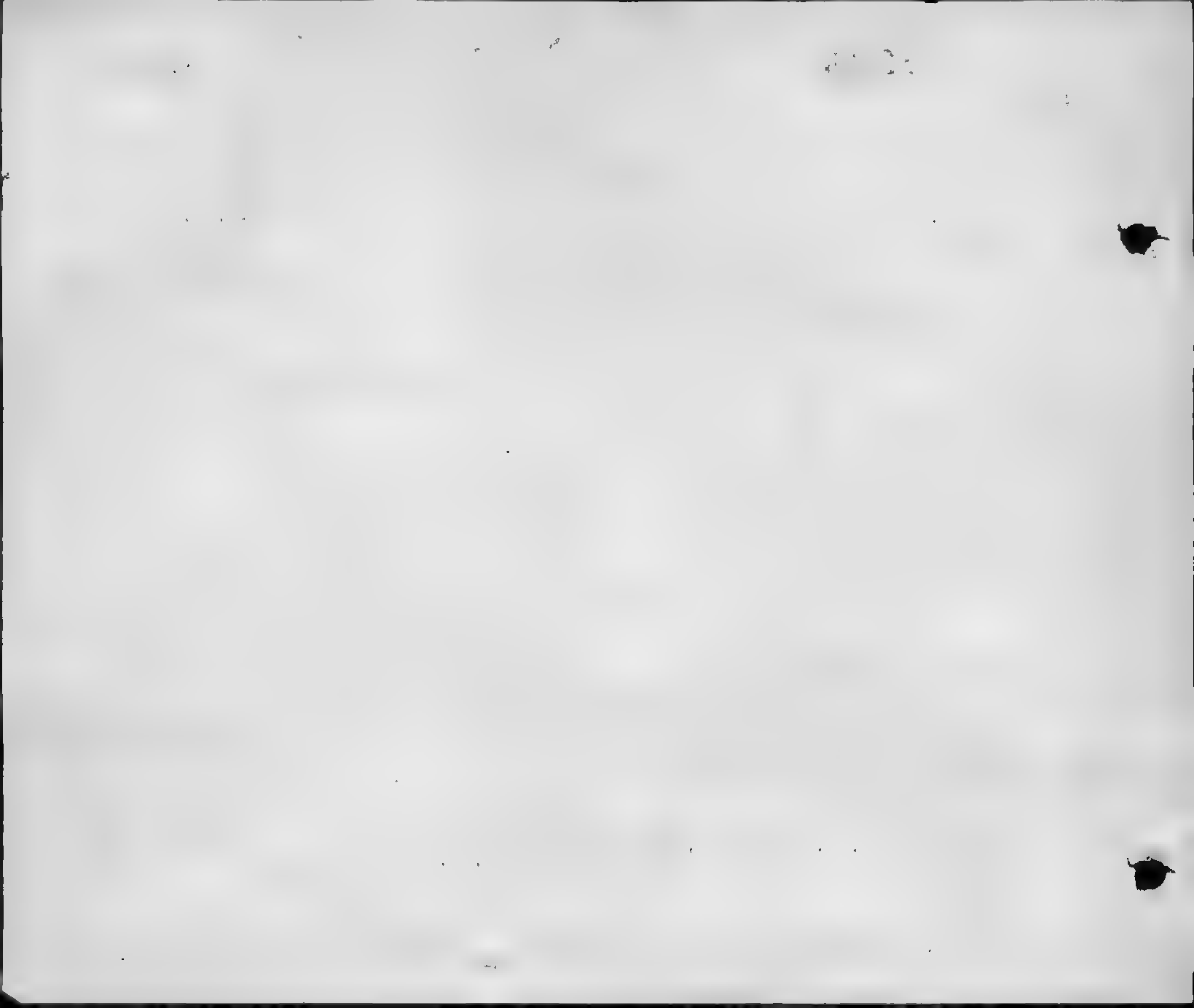
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10469

## CERTIFICATE OF DEATH

10462

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery<br>b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)<br>c. LENGTH OF STAY IN 1b<br>115 days<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>U. S. Naval Hospital   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>District of Columbia<br>b. COUNTY<br>✓<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Washington<br>d. STREET ADDRESS<br>4201 Cathedral Ave., N. W.<br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Ethyl<br>Minn<br>Tassa<br>4. DATE OF DEATH<br>September 15 1961  |  | 5. SEX<br>Female<br>6. COLOR OR RACE<br>Caucasian<br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH<br>12-19-93<br>9. AGE (In years last birthday)<br>67 yrs.<br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife<br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country)<br>Ohio<br>12. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 13. FATHER'S NAME<br>George Ogan<br>14. MOTHER'S MAIDEN NAME<br>Adela McPherson Ferguson<br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No<br>16. SOCIAL SECURITY NO.<br>17. INFORMANT<br>Michael Tassa (H) Same as #2 above   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i><br>DUE TO<br>(b) <i>Cerebral Vascular Accident</i><br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  |  | INTERVAL BETWEEN ONSET AND DEATH<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |  | 21. I certify that (this hospital) attended the deceased from May 23 1961 to September 15 1961 that (we) last saw the deceased alive on September 15 1961, and that death occurred at 4:00 PM from the causes and on the date stated above.<br>22a. SIGNATURE<br><i>Robert A. Pumphrey</i><br>22c. PHYSICIAN'S NAME (Type)<br>W. F. WARRANDER, LT MC USN<br>22d. ADDRESS<br>U. S. Naval Hospital Bethesda, Md.<br>22b. DATE SIGNED<br>15 Sept 1961 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial<br>23b. DATE THEREOF<br>19 Sept 1961<br>23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National<br>23d. LOCATION (City, town or county)<br>Arlington Va<br>(State)  |  | 24. FUNERAL DIRECTOR'S SIGNATURE<br>Robert A. Pumphrey, 1551 Wisconsin Ave, Bethesda, Md.<br>25a. REC'D BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br>SEP 19 '61   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

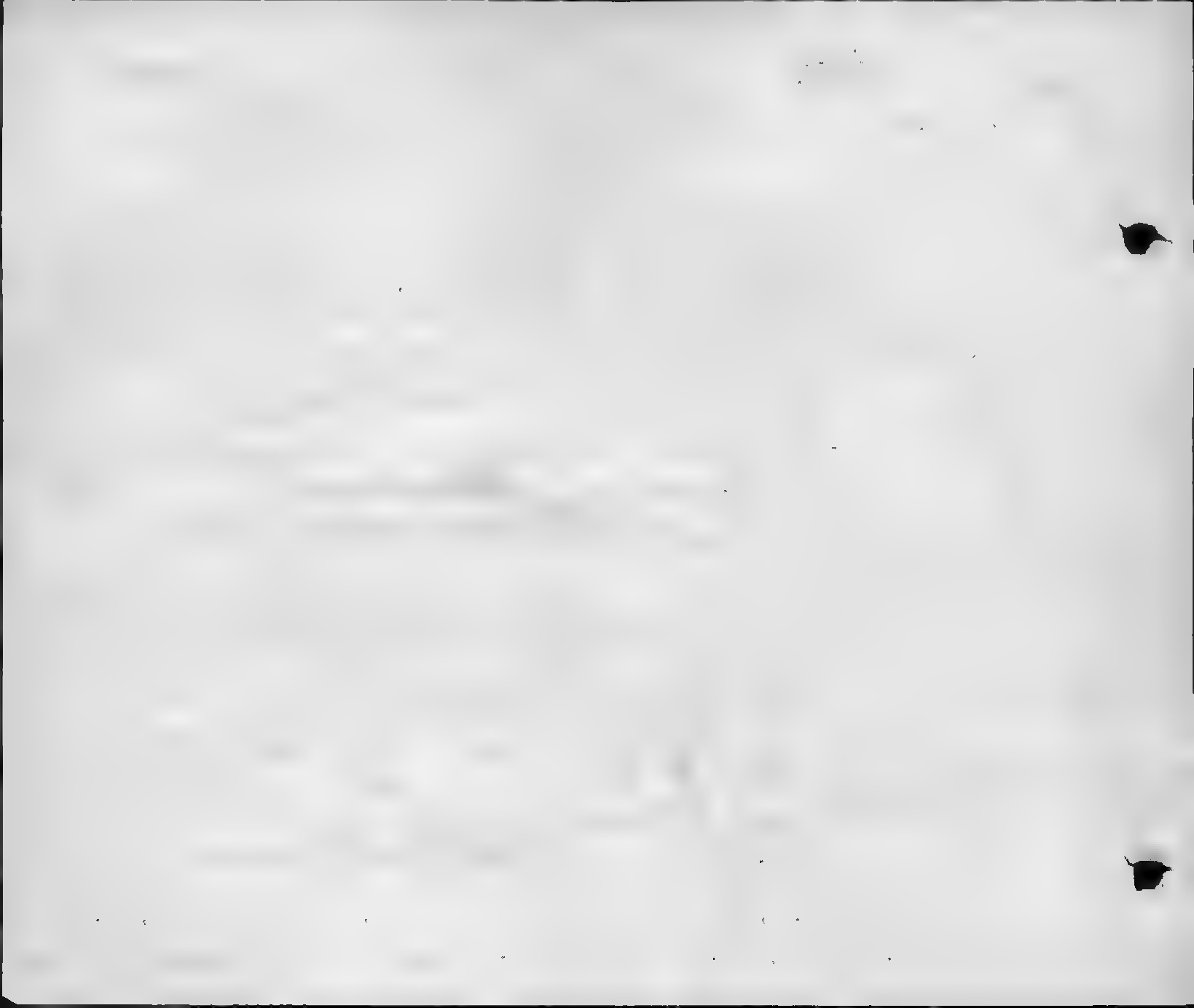
## CERTIFICATE OF DEATH

10470

10463

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY in 1b <u>2 hrs 10 min.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>301 Southwest Drive</u>    |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Irene Lincoln Taylor</u>  |  | <b>4. DATE OF DEATH</b><br><u>September 4, 1961</u>   |  |
| <b>5. SEX</b><br><u>Female</u>   |  | <b>6. COLOR OR RACE</b><br><u>White</u>   |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12, 1902</u>   |  | <b>9. AGE</b> (In years last birthday) <u>59</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>  |  |
| <b>11. BIRTHPLACE</b> County & State, or foreign country <u>Massachusetts</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |
| <b>13. FATHER'S NAME</b> <u>Edmond Rideout</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Sadie Phipps</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>  |  | <b>16. SOCIAL SECURITY NO</b> <u>None</u>   |  |
| <b>17. INFORMANT</b> <u>Washington Sanitarium and Hospital Records</u>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary disease</u><br>(c) |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | <b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 hrs</u>  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Diabetes Mellitus</u>  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 4, 1961</u> <b>to</b> <u>Sept 4, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Sept 4, 1961</u> , <b>and that death occurred at</b> <u>2:25 P.M.</u> , <b>from the causes and on the date stated above.</b>                         |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Lester W. Harris</u>   |  | <b>22b. DATE SIGNED</b><br><u>9/4/61</u>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Lester W. Harris</u>  |  | <b>22d. ADDRESS</b><br><u>507 Northwest Dr. SS Md</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>   |  | <b>23b. DATE THEREOF</b> <u>Sept. 7, 1961</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery</u>   |  | <b>23d. LOCATION (City, town or county)</b> <u>Arlington County, Va.</u>  |  |
| <b>24. BURIAL DIRECTOR'S SIGNATURE</b> <u>Raymond Ziska</u>  |  | <b>25a. REC'D BY REGISTRAR</b> <u>SEP 6 '61</u>   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>   |  | <b>25c. REGISTRAR'S NAME</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

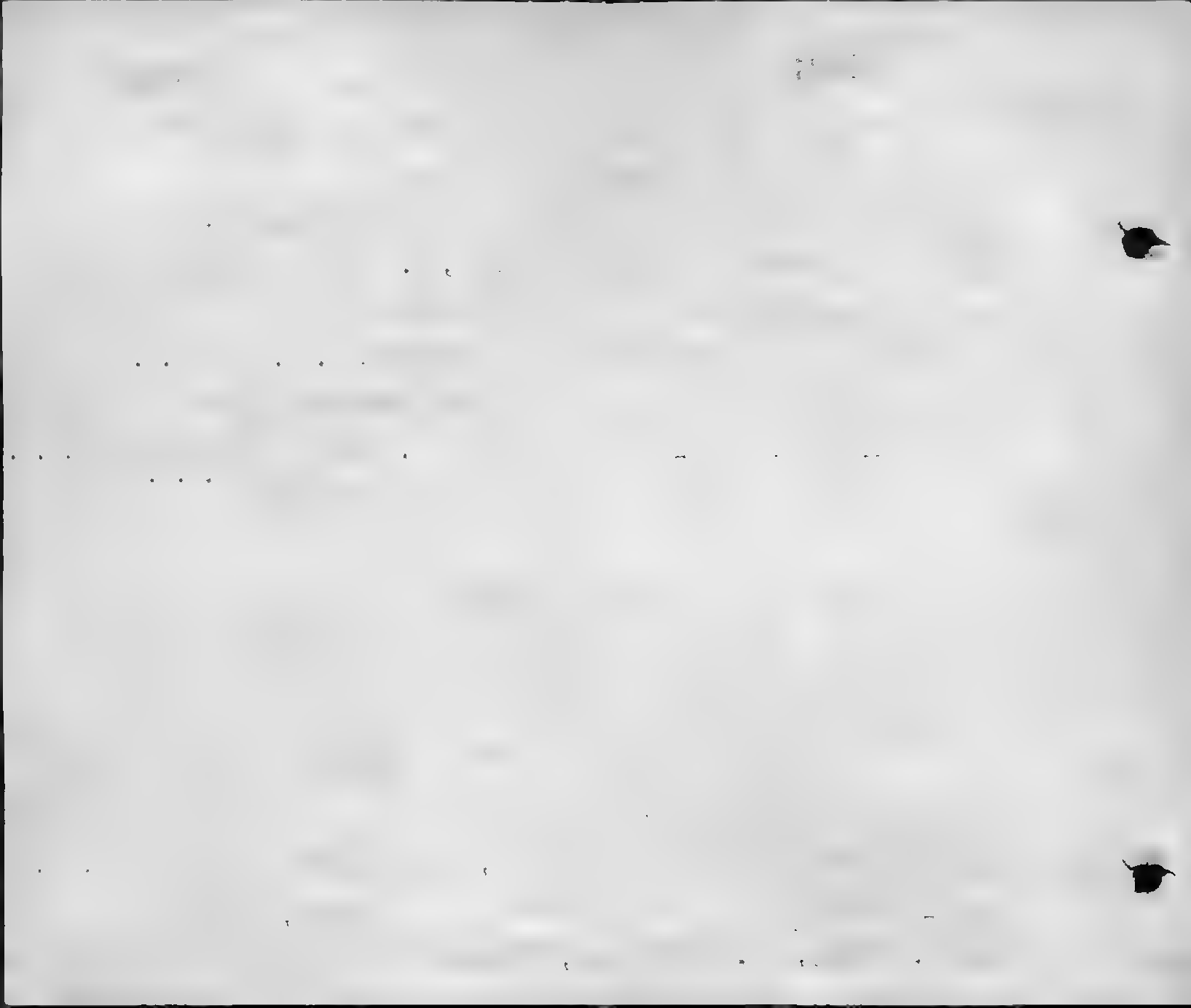
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10471

## CERTIFICATE OF DEATH

10464

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u><br>d. STREET ADDRESS <u>12008 GRANDVIEW AVE.</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WHEATON NURSING HOME</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Stephen Taylor, Jr.</u>   |  | 4. DATE OF DEATH <u>9 25 19 61</u>   |  |
| 5. SEX <u>MALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>10/16/1885</u>   |  |
| 9. AGE (in years last birthday) <u>76</u> yrs.   |  | 10. IF UNDER 1 YEAR: Months Days Hours Mins.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILE</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>HERIKIMER, N. Y.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>STEPHEN TAYLOR</u>  |  | 14. MOTHER'S MAIDEN NAME <u>CORA (UNKNOWN) DOCKSTADER</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>  |  | 16. SOCIAL SECURITY NO. <u>577-10-0589</u>   |  |
| 17. INFORMANT <u>FLORENCE L. TAYLOR</u>  |  | Address <u>1365 KENNEDY ST. N.W. WASH. D.C.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastro-Intestinal hemorrhage</u><br>DUE TO <u>4:00</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Mesenteric thrombosis</u><br>DUE TO <u>Arteriosclerosis</u><br>(a), stating the underlying cause last (c) <u>Diabetes mellitus</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u><br><u>2 months</u><br><u>4 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August 1953</u> to <u>Sept 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 25, 1961</u> , and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <u>John Lawrence Avery</u>  |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN LAWRENCE AVERY</u>  |  | 22d. ADDRESS <u>10,110 GEORGIA AVENUE, SILVER SPRING, MD.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT-BURIAL 9/29/61</u>  |  | 23b. DATE THEREOF  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>  |  | 23d. LOCATION (City, town or county) (State) <u>HERKIMER, NEW YORK</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>   |  | 25a. REC'D BY REGISTRAR <u>SEP 28 '61</u>  |  |
| ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

# MARYLAND STATE DEPARTMENT OF HEALTH

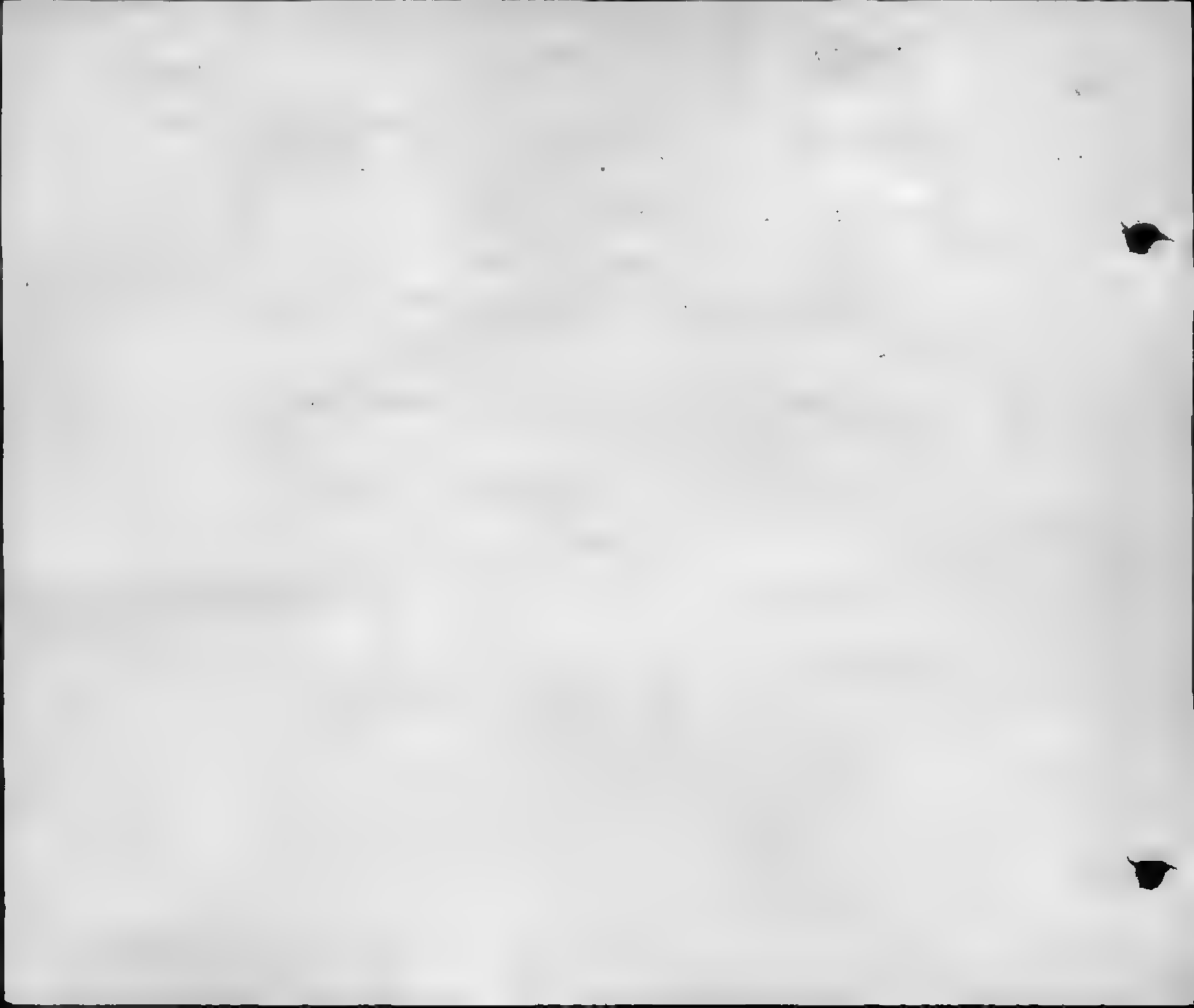
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10472

## CERTIFICATE OF DEATH

10465

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Gaithersburg</b>                                       |  |
| c. LENGTH OF STAY in 1b<br><b>2hrs. 17mins</b>  |  | d. STREET ADDRESS<br><b>1</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Montgomery General Hospital</b>  |  |   |  |
| a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Lilly Mae Thomas</b>   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>11</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>5/25/1898</b>  |  |
| 9. AGE (In years last birthday) <b>63</b> yrs   |  | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>11</b> Hours <b>17</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Maryland</b>   |  |
| 13. FATHER'S NAME<br><b>George Thomas</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Ross</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO. 17. INFORMANT Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b>   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Gangrene Sigmoid Colon</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>9-11-61</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                     |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 9-11-61</b> to <b>Sept 11-61</b> , that (I) (we) last saw the deceased alive on <b>Sept 11-61</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><b>Luciano C. Leal</b>  |  | 22b. DATE SIGNED<br><b>9-13-61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Luciano C. Leal</b>  |  | 22d. ADDRESS<br><b>Gaithersburg, Md.</b>  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/15/61</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ash Memorial Cem</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Sandy Spring, Md</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert L. Shauden</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 '61</b>   |  |
| ADDRESS<br><b>Rockville Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneal</b>  |  |



VS. A15ME  
5M 7/59



# MARYLAND STATE DEPARTMENT OF HEALTH

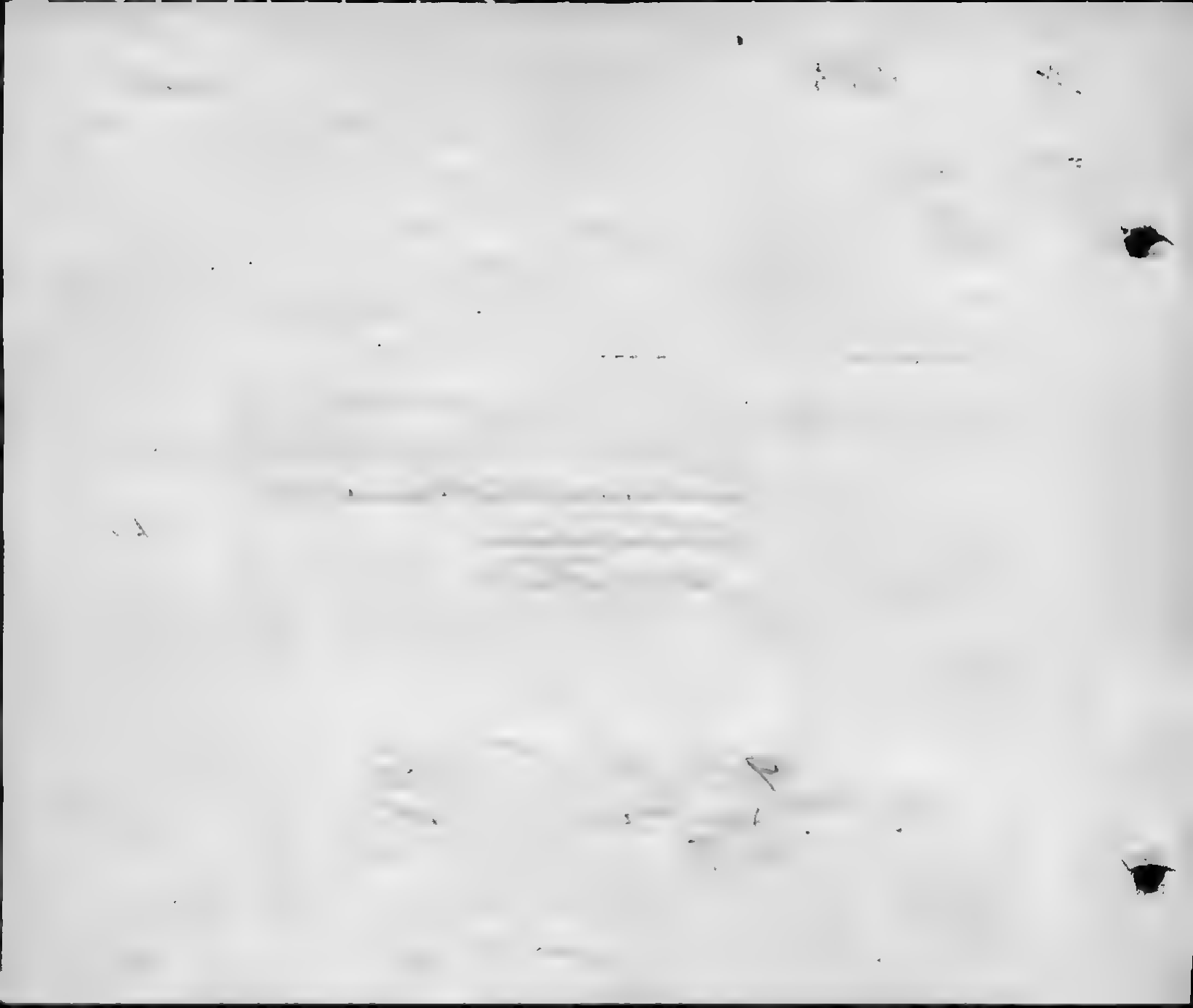
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10474

10467

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; not before admission)<br>a. STATE<br><b>Maryland</b>   |  | b. COUNTY<br><b>Montgomery</b>  |  |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Bethesda</b>  |  | c. LENGTH OF STAY IN Bldg.<br><b>4</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>5904 Sonoma Road</b>   |  | d. STREET ADDRESS<br><b>5904 Sonoma Road</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>VIRGINIA A THOMAS</b>  |  | 4. DATE OF DEATH<br><b>Sept. 8, 1961</b>   |  | 5. SEX<br><b>Female</b>   |  |
| 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 28, 1887</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                              |  |
| 13. FATHER'S NAME<br><b>James Magruder</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Frances Mulligan</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>(D) Thelma Weigle, College Pk. Md</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br>DUE TO <b>Arteriosclerosis</b><br>DUE TO <b>Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                              |  |
| 20f. (City or town)   |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/5/53</b> to <b>9/8/61</b> , that (I) (we) last saw the deceased alive on <b>9/8/61</b> , and that death occurred at <b>8 p.m.</b> from the causes and on the date stated above  |  |  |  |   |  |
| 22a. SIGNATURE<br><b>William Joyce</b>  |  | 22b. DATE SIGNED<br><b>9/8/61</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>William Joyce</b>  |  |
| 22d. ADDRESS<br><b>8106 Maple Ridge Rd. Beth. Md</b>  |  | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>          |  |   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/11/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                    |  |
| 23d. LOCATION (City, town or county)<br><b>Suitland, Maryland</b>   |  | 23e. (State)   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |  | 24a. ADDRESS<br><b>Bethesda, Maryland</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 14 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |  | 25c. (State)   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

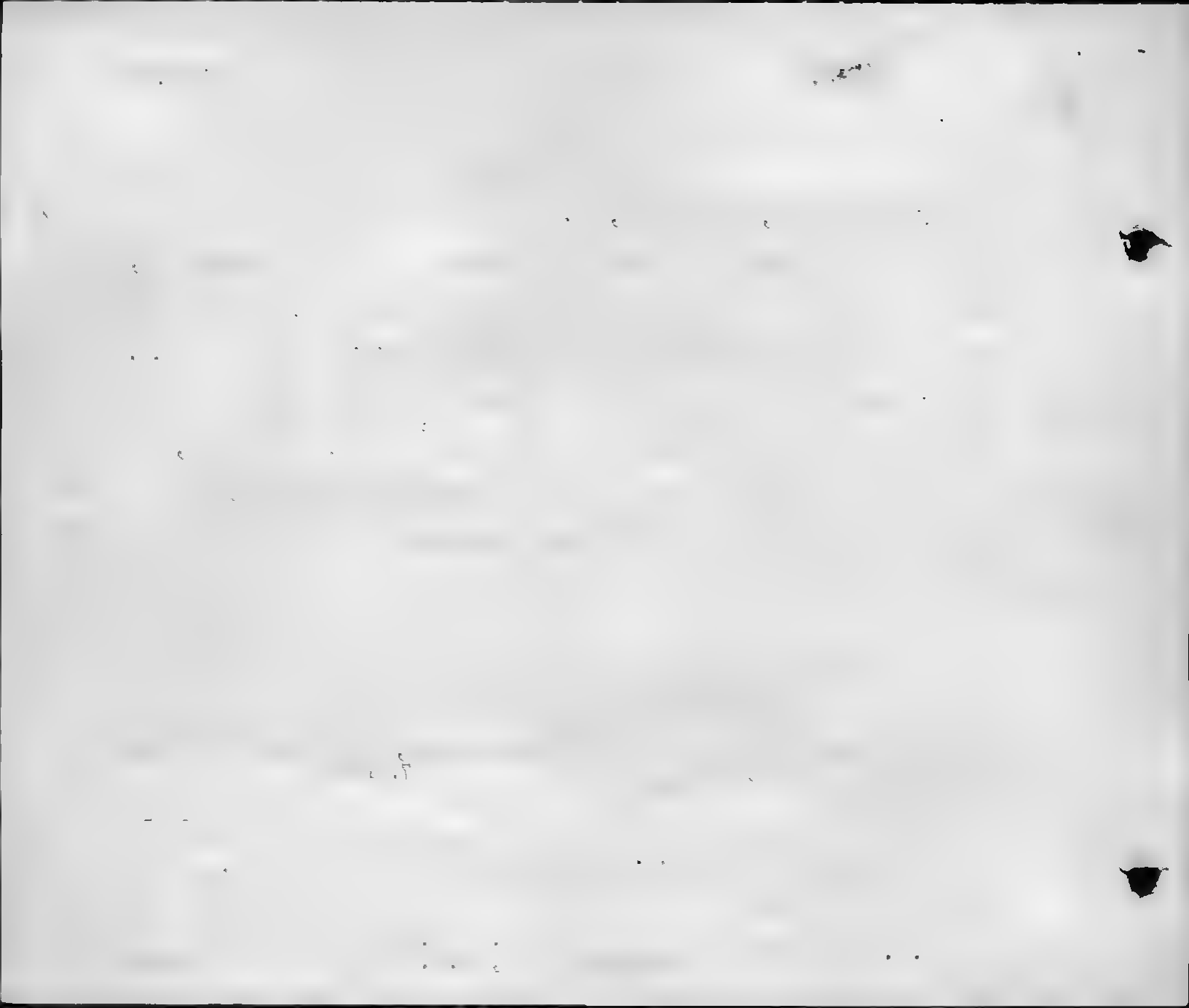
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10475

10468

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY (in hospital, give street address)<br><b>10 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>West Virginia</b><br>b. COUNTY<br><b>Holden</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Holden</b><br>d. STREET ADDRESS<br><b>No street address</b>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>Vicky Lynn Thompson</b>   |  | <b>4. DATE OF DEATH</b><br>Month <b>September</b> Day <b>23</b> Year <b>1961</b>  |  |
| <b>5. SEX</b><br><b>Female</b>  |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><b>July 21, 1958</b>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Child</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>None</b>   |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>West Virginia</b>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Alvin Thompson</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Mavis Stafford</b>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b>   |  |
| <b>17. INFORMANT</b><br><b>The Medical Record</b>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Post operative - Pulmonic Stenosis &amp; Pulmonary Hypertension</b><br><b>754.5</b> DUE TO (b) <b>Congenital Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>DUE TO (c) <b>Birth</b> |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>   |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> Enter nature of injury in Part I or Part II of item 18)  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <b>5</b> a.m. <b>19</b> p.m.  |  |   |  |
| <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)<br><b>September 14, 1961</b> <b>September 23, 1961</b>  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <b>September 14, 1961</b> to <b>September 23, 1961</b>, that (I) (we) last saw the deceased alive on <b>September 23, 1961</b>, and that death occurred at <b>8:11 AM</b> from the causes and on the date stated above.</b>  |  |   |  |
| <b>22a. SIGNATURE</b><br><b>W. Douglas Clark</b> M.D.   |  |   |  |
| <b>22b. DATE SIGNED</b><br><b>9-23-61</b>   |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>W. Douglas Clark M.D.</b>   |  |   |  |
| <b>22d. ADDRESS</b><br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>   |  |   |  |
| <b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b><br>REMOVAL (Specify)<br><b>removal 19/24/61</b>  |  |   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>23d. LOCATION (City, town or county) (State)</b><br><b>Holden, West Virginia</b>  |  |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>The S.H. Hines Company</b>  |  |   |  |
| <b>25. REGISTRAR'S SIGNATURE</b><br><b>SEP 26 '61</b>   |  |   |  |



V5. A15ME  
5M 7/59



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

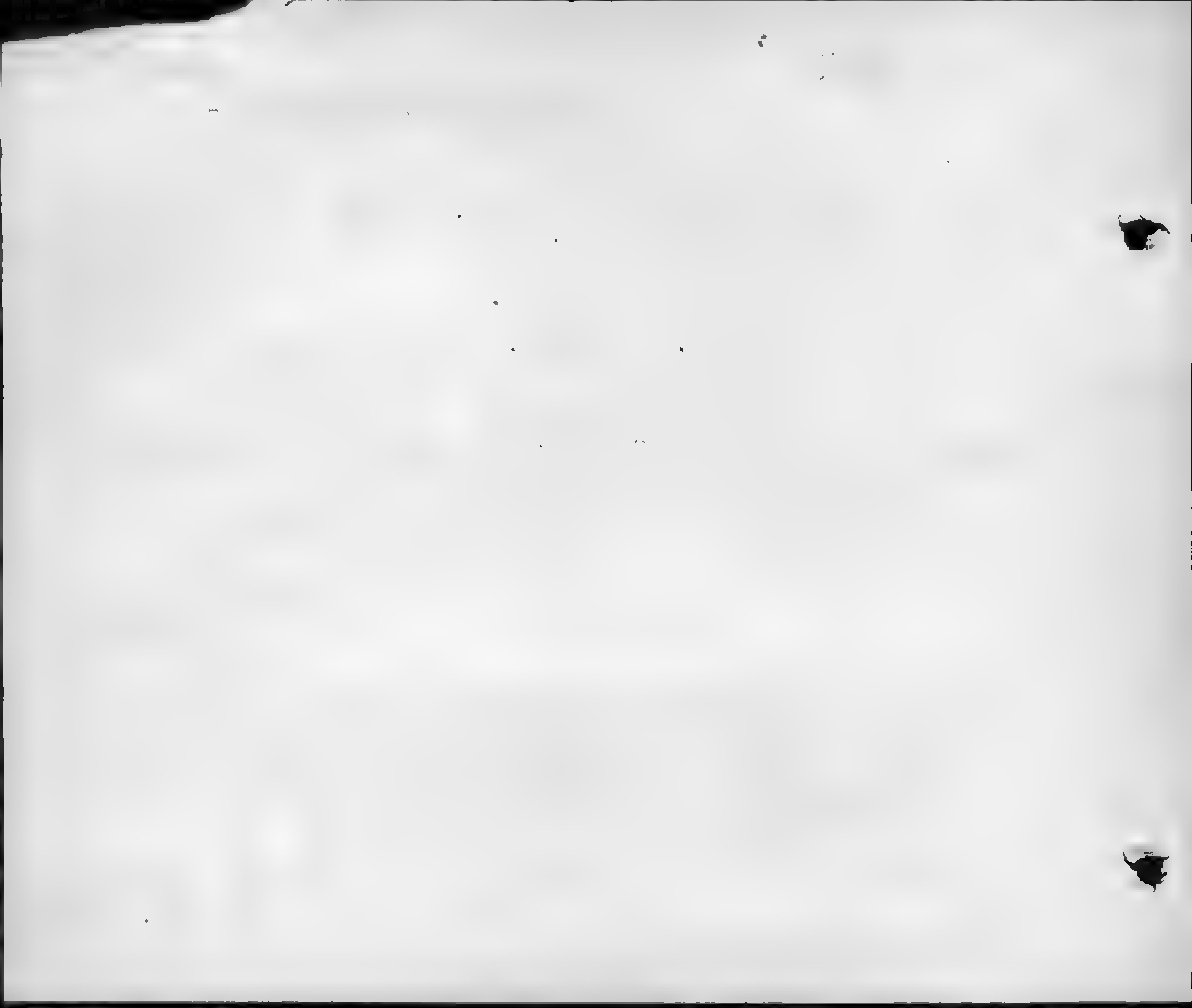
10477

10470

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Montgomery</u> MARYLAND - <u>Montgomery</u> COUNTY  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>   |  |  |  |
| c. LENGTH OF STAY IN 1b <u>3 da</u>   |  |  |  | d. STREET ADDRESS <u>4309 Colchester Drive</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tan Kensington Gardens</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>4</u> Middle <u>TURNER</u> Last <u>Sr.</u>  |  |  |  | 4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1961</u>  |  |  |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>white</u>                              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Jan. 2, 1912</u>   |  |
| 9. AGE (in years lost birthday) <u>49</u> yrs   |  | IF UNDER 1 YEAR Months <u></u> Days <u></u>                |  | IF UNDER 24 HRS Hours <u></u> Min <u></u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Met. Police Dept.</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                       |  |
| 13. FATHER'S NAME <u>Samuel G. Turner</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Groce A. Thomas</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>214-03-8596</u>                 |  | 17. INFORMANT Address <u>Nursing Home Records Kensington, Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UREMIA, Acute</u><br>181.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal failure - Metastatic Carcinoma</u><br>DUE TO (c) <u>Primary Carcinoma Urinary Bladder</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u><br>INTERVAL BETWEEN ONSET AND DEATH <u></u> |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-9-1961</u> to <u>9-9-1961</u> . That (I) (we) last saw the deceased alive on <u>9-9-1961</u> , and that death occurred at <u>4:20 PM</u> from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>R. Thibadeau</u>  |  |  |  | 22b. DATE SIGNED   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU, MD</u>   |  |  |  | 22d. ADDRESS <u>10609 CONCORD ST. KENSINGTON</u>   |  |  |  |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>9/12/61</u>                           |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Maryland</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Kinn Co.</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>290144-1800</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MONTGOMERY COUNTY, MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10478

10471

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN 1b 2 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium Hospital 1518 E. 172nd ST

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
e. STATE New York b. COUNTY Beacon  
c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Beacon  
d. STREET ADDRESS Beacon

3. NAME OF DECEASED (Type or print) Ubaldo (George) Vatore  
4. DATE OF DEATH 9/14/1961  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

5. SEX Male 6. COLOR OR RACE Italian 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 2-16-'90 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hair-Dresser (Retired)-Self Employed 10b. KIND OF BUSINESS OR INDUSTRY Italy 11. BIRTHPLACE (County & State, or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME Gennaro Vatore 14. MOTHER'S MAIDEN NAME Lucy UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Yes 17. INFORMANT Hospital Records Address UNKNOWN

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute Bronchopneumonia  
DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Chronic Congestive Heart Failure  
(c) 1 yr.  
causing the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

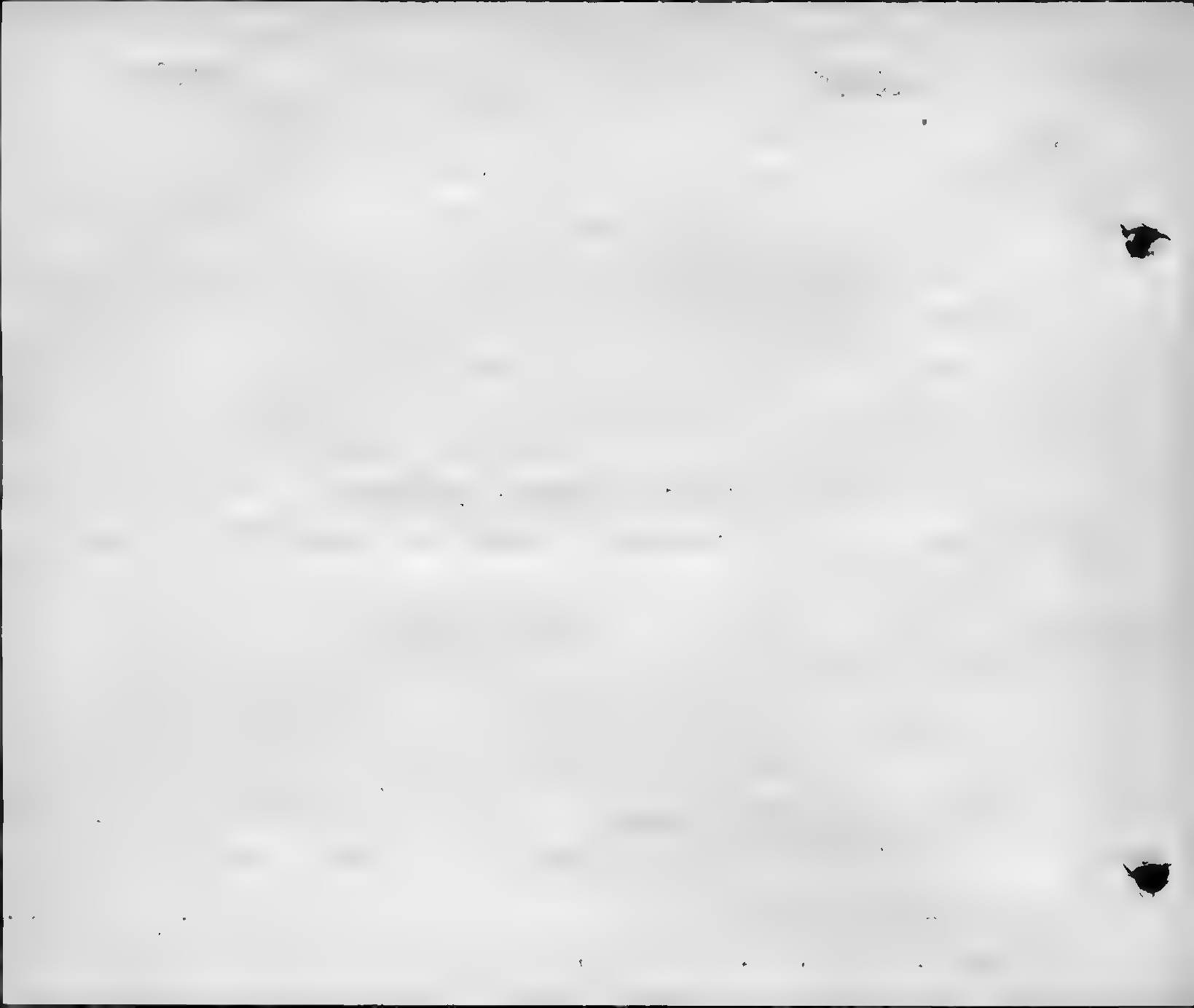
21. I certify that (I) (this hospital) attended the deceased from 9-12 1961 to 9-14-61 19, that (I) was last saw the deceased alive on 9-13-61 19, and that death occurred at 2:30 AM, from the causes and on the date stated above.

22a. SIGNATURE Richard L. Clapp M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ DATE SIGNED 9-14-61  
22c. PHYSICIAN'S NAME (Type) Richard L. Clapp MD 22d. ADDRESS 7600 CARROLL AVE TAKOMA PARK, MD

23a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 23b. DATE THEREOF 9/18/61 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 23d. LOCATION (City, town or county) (State) Queens, Queens Co. New York, N.Y.

24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska ADDRESS 813 Georgia Avenue Silver Spring, Maryland 25a. REC'D BY REGISTRAR SEP 19 1961 25b. REGISTRAR'S SIGNATURE Charles S. Howard

TO REGISTERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

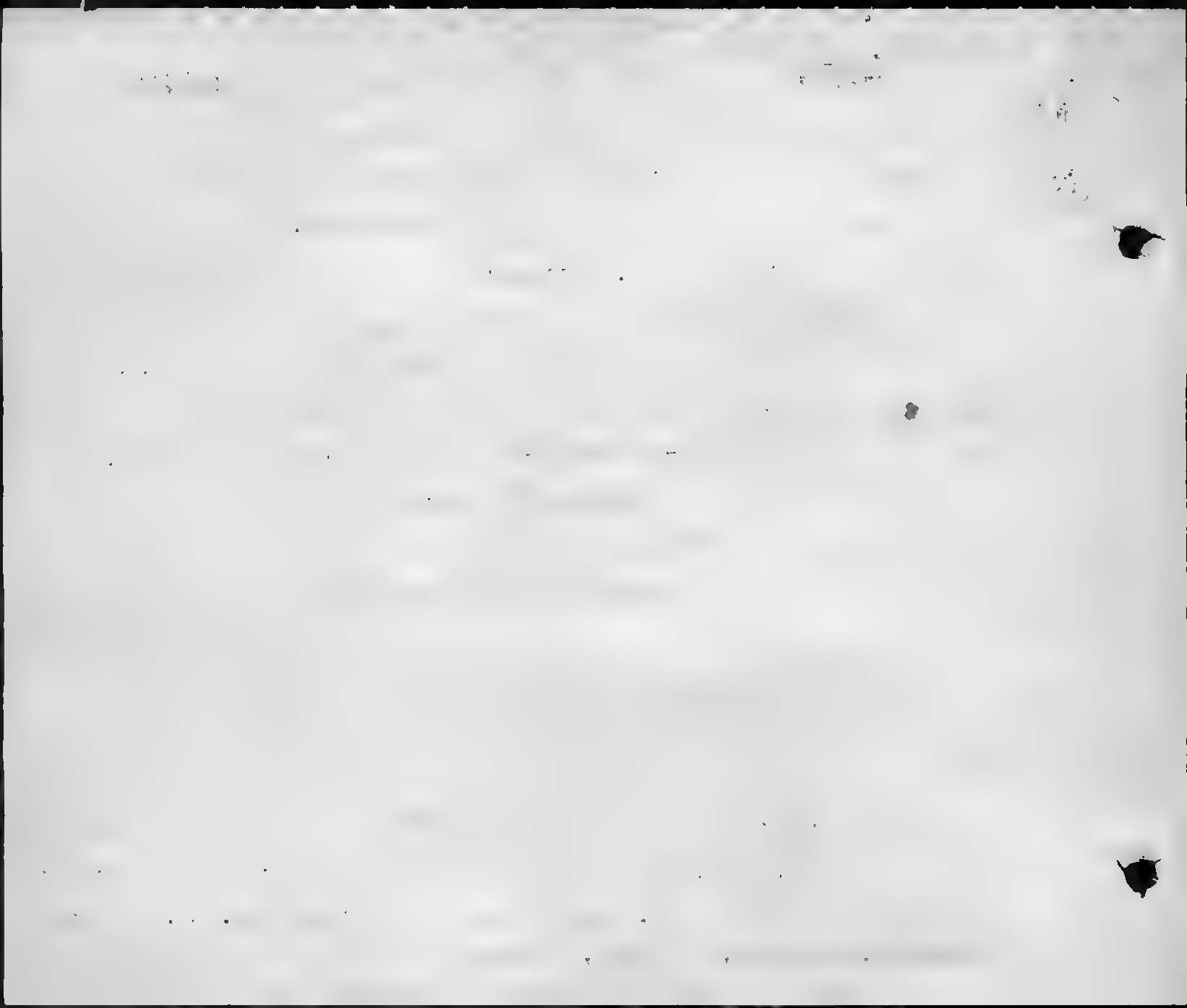
10479

## CERTIFICATE OF DEATH

10472

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY (In 1b) <u>3 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>    |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u><br>d. STREET ADDRESS <u>10519 Warfield St.</u> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>William</u> Middle <u>A.</u> Last <u>Wagner</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>Sept.</u> Day <u>24</u> Year <u>1961</u>   |  |
| <b>5. SEX</b><br><u>Male</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>July 28, 1884</u>  |  |
| <b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |  | <b>9b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Retired</u>  |  |
| <b>10. FATHER'S NAME</b><br><u>John A. Wagner</u>   |  | <b>11. BIRTHPLACE</b> (County & State or foreign country)<br><u>Maryland</u>   |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  | <b>13. MOTHER'S MAIDEN NAME</b><br><u>Elizabeth Scherer</u>  |  |
| <b>14. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | <b>15. SOCIAL SECURITY NO.</b><br><u>Yes-Unknown</u>   |  |
| <b>16. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Vascular Disease</u><br>(b) <u>Uremia</u><br>(c) <u>Urinary tract infection</u>  |  | <b>17. INTERVAL BETWEEN ONSET AND DEATH</b><br><u>609 X</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):<br><u>None</u>   |  |  |  |
| <b>18a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>18b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>19a. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  | <b>19b. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>19c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>19d. (City or town)</b> (County) (State)  |  |
| <b>20. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 1958</u> <b>to</b> <u>Sept. 24, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Sept. 23, 1961</u> <b>and that death occurred at</b> <u>7 A.M.</u> <b>from the causes and on the date stated above.</b> |  |  |  |
| <b>21a. SIGNATURE</b><br><u>George Sharpe</u><br><b>21c. PHYSICIAN'S NAME</b> (Type)<br><u>GEORGE SHARPE</u><br><u>George Sharpe</u>  |  | <b>21b. DATE SIGNED</b><br><u>Sept. 24, 1961</u><br><b>21d. ADDRESS</b><br><u>10511 Summit Ave., Kensington, Md.</u>   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>22b. DATE THEREOF</b><br><u>9/27/61</u>   |  |
| <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Ft. Lincoln Cemetery</u>  |  | <b>22d. LOCATION</b> (City, town or county) (State)<br><u>Prince Geo. Co. Maryland</u>   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Robert A. Pumphrey, Bethesda, Maryland</u>  |  | <b>24a. REC'D BY REGISTRAR</b><br><u>SEP 27 '61</u>  |  |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur E. Hays</u>  |  | <b>24c. DATE</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

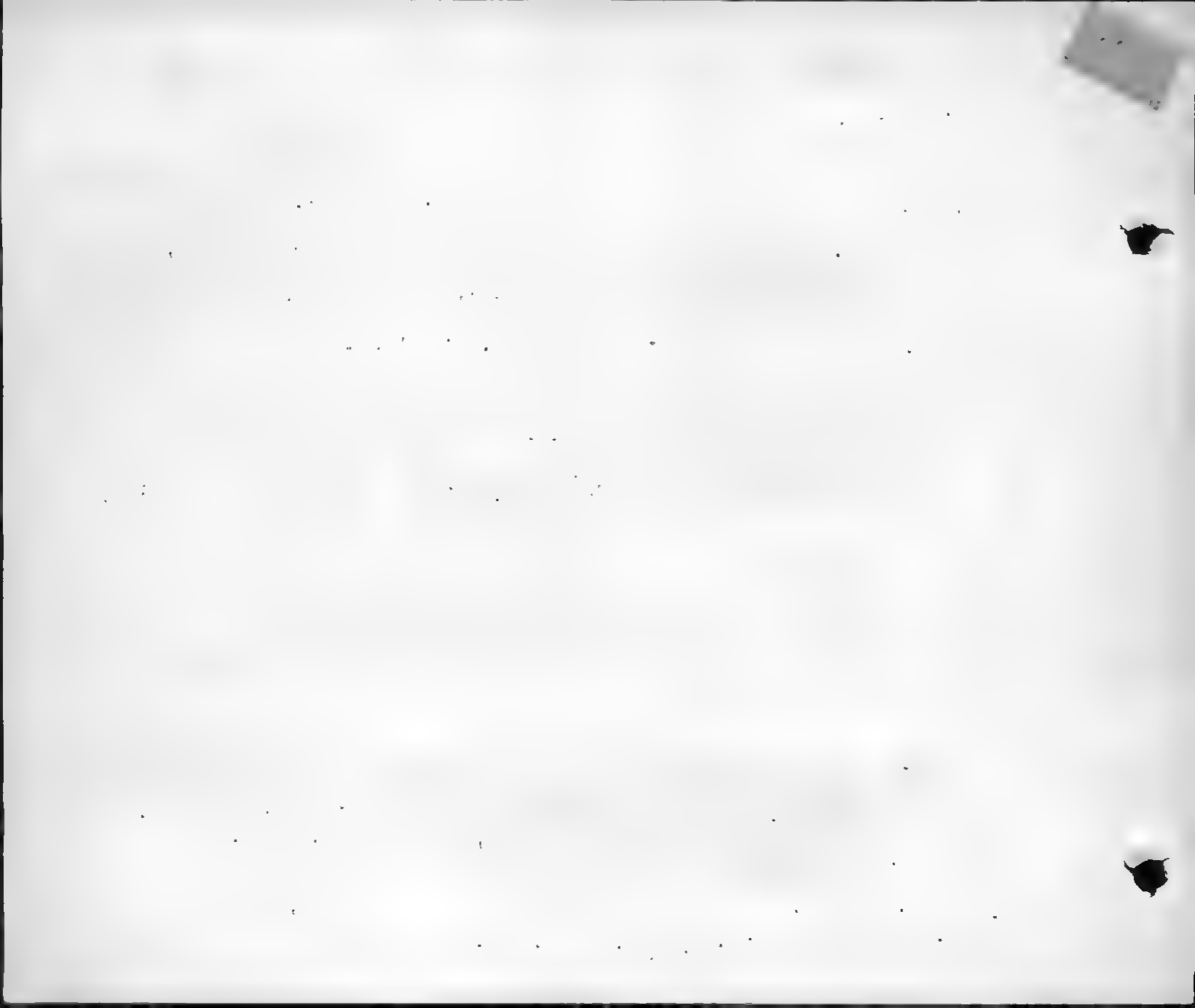
10480

10473

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Kensington</u>  |   | c. LENGTH OF STAY IN 1b<br><u>42</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>2711 Kensington Ave.</u>   |   | d. STREET ADDRESS<br><u>2711 Kensington Ave.</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Morris Perry</u>  |   | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>26</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 21, 1902</u>  |
| 9. AGE (In years last birthday)<br><u>78</u> yrs   |   | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>  | 11. IF UNDER 24 HRS<br>Hours <u>  </u> Min <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Own Home</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>St. John's, Michigan</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Jacob Poersch</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Matilda Weller</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   |
| 17. INFORMANT<br><u>L.J. Waldron-Item # 2</u>  |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of lung</u><br><u>163X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>  </u> DUE TO (c) <u>  </u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>18-24 mos.</u>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>12-1-59</u> , 19 <u>  </u> , to <u>9-26</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9-25</u> , 19 <u>61</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.                                       |   |   |   |
| ACTUAL SIGNATURE <u>Morris Perry</u> M.D.  |   | ADDRESS (Street, city or town, state) <u>11602 Rockledge Ave. Wheaton, Silver Spring, Maryland</u>  |   |
| DATE SIGNED <u>9/26/61</u>   |   |   |   |
| PHYSICIAN'S NAME (Type) <u>Morris Perry</u>  |   |   |   |
| 22a. BURIAL, CREMATION REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>9/27/61</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rockville</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Rockville, Md.</u>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Rockville, Md.</u>  |   | 24. ADDRESS.  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 29 1961</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Guthrie L. Hanna</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9 60

MEDICAL CERTIFICATION

10481 10474

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring  
c. LENGTH OF STAY IN b 150 A.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 18411 Youth Rd  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)  
a. STATE MD b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring  
d. STREET ADDRESS 18411 Youth Rd  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
First Middle Last William Edward Walker  
4. DATE OF DEATH  
Month Day Year Sept 20 1961

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH  
Month Day Year 2-16-48 9. AGE (in years, last birthday) 13 yrs. 10. IF UNDER 1 YEAR: Months 7 Days 4 11. IF UNDER 24 HRS: Hours 7 Min. 4

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School 10b. KIND OF BUSINESS OR INDUSTRY Cal 11. BIRTHPLACE (State or foreign country) Cal 12. CITIZEN OF WHAT COUNTRY? U.S.C.

13. FATHER'S NAME William Walker 14. MOTHER'S MAIDEN NAME Florance Aiken

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 111-11-1111 17. INFORMANT Florance Walker Address Stim 2

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 813X DUE TO Exsanguination  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. laceration Rt carotid Artery  
DUE TO Struck by car  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
INTERVAL BETWEEN ONSET AND DEATH Sudden  
Sudden  
Sudden

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. Primary  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Running bicycle when struck by auto  
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 9-20-1961 20d. INJURY OCCURRED: 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) Silver Spring (County) Montgomery (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brosehart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 9-21-61

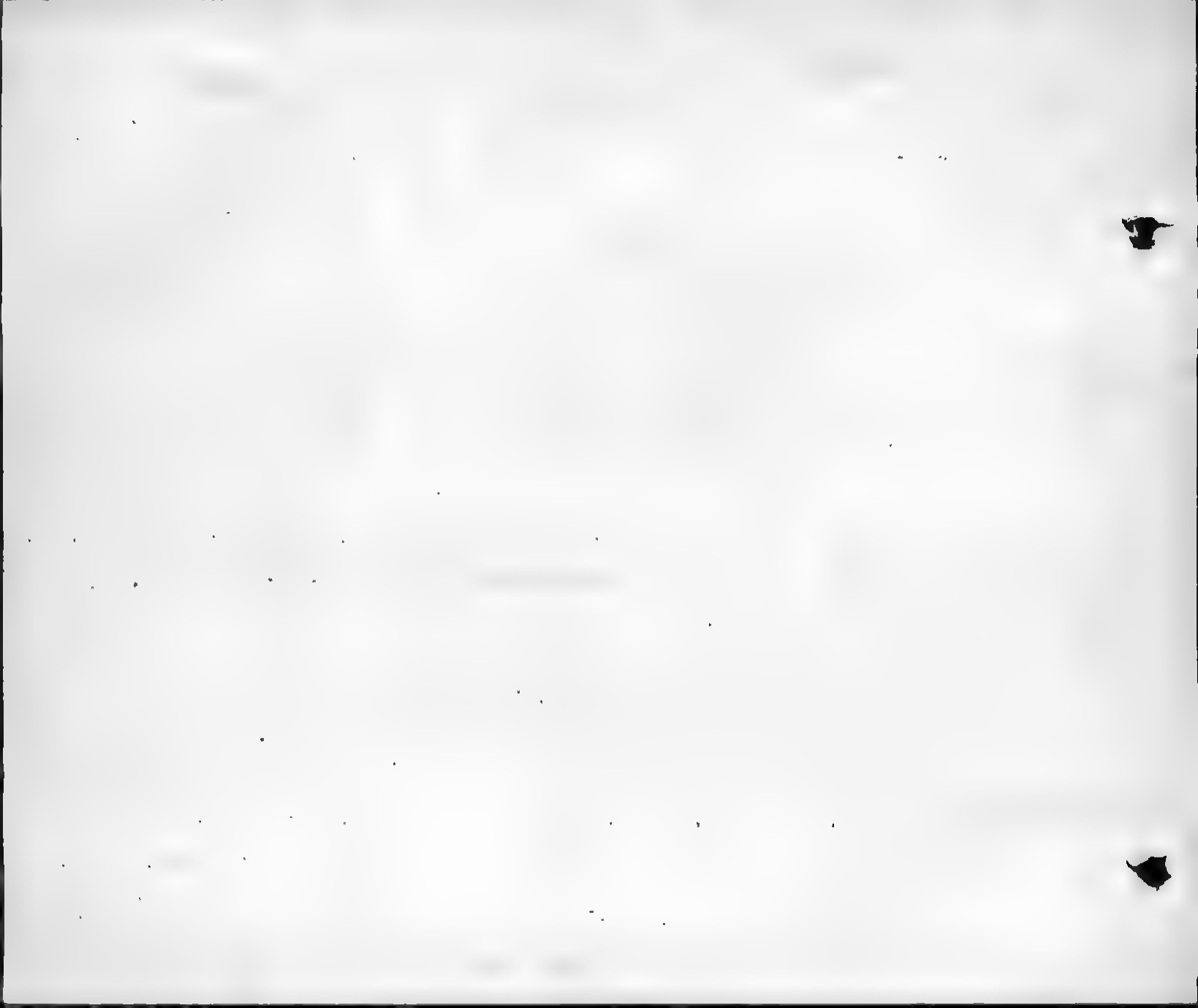
EXAMINER'S NAME (Type) FRANK J. BROSEHART Address (Street, city, town, or county) 1111

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-25-61 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery 22d. LOCATION (City, town, or country) (State) Washington D.C.

23. FUNERAL DIRECTOR Arthur C. Farnham ADDRESS 1111 24a. REC'D BY REGISTRAR SEP 25 '61 24b. REGISTRAR'S SIGNATURE Arthur C. Farnham









FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
SM 9 60

10483  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10476

1. PLACE OF DEATH  
a. COUNTY *Montgomery* b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Garthman* c. LENGTH OF STAY IN 1b *1* d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) *Ind Route 28*

2. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)  
a. STATE *md* b. COUNTY *Montgomery* c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Garthman* d. STREET ADDRESS *Ind Route 28*

3. NAME OF DECEASED (Type or print) *Wilson, Richard* 4. DATE OF DEATH *Sept 17 1961*

5. SEX *male* 6. COLOR OR RACE *white* 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH *5-11-1895* 9. AGE (In years last birthday) *66* yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *labour* 11. BIRTHPLACE (State or foreign country) *md* 12. CITIZEN OF WHAT COUNTRY? *U.S.A.*

13. FATHER'S NAME *Pete Ward* 14. MOTHER'S MAIDEN NAME *Martha Whalen*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *no* 16. SOCIAL SECURITY NO *17* 17. INFORMANT *Frances Ward (wife)* Address *Ind 2*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *976X* DUE TO *Cerebral hemorrhage + laceration*  
Conditions, if any, which gave rise to immediate cause (b) *Shot gun wound thru skull* DUE TO *Shot gun wound thru skull*  
(a), stating the underlying cause last. (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) *Self-inflicted shot gun wound*

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18) *Self-inflicted shot gun wound*

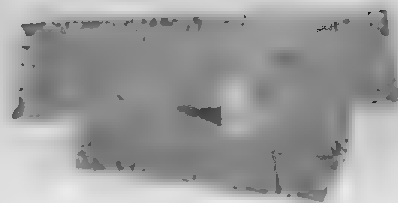
20c. TIME OF INJURY Month Day, Year *9-17 1961* 20d. INJURY OCCURRED While ☐ Not While ☒ el work ☐ el work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) *Home* 20f. (City or town) *Garthman* (County) *Montgomery* (State) *md*

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Frank J. Brosch* EXAMINER'S NAME (Type) *FRANK J. Brosch* CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) *12/20/61* 22b. DATE THEREOF *12/20/61* 22c. NAME OF CEMETERY OR CREMATORY *Ind 1* 22d. LOCATION (City, town, or country) *Ind* (State) *md*

23. FUNERAL DIRECTOR ADDRESS *Ind 1* 24a. REC'D BY REG. STRAR *SEP 19 61* 24b. REGISTRAR'S SIGNATURE *Arthur L. House*



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10484

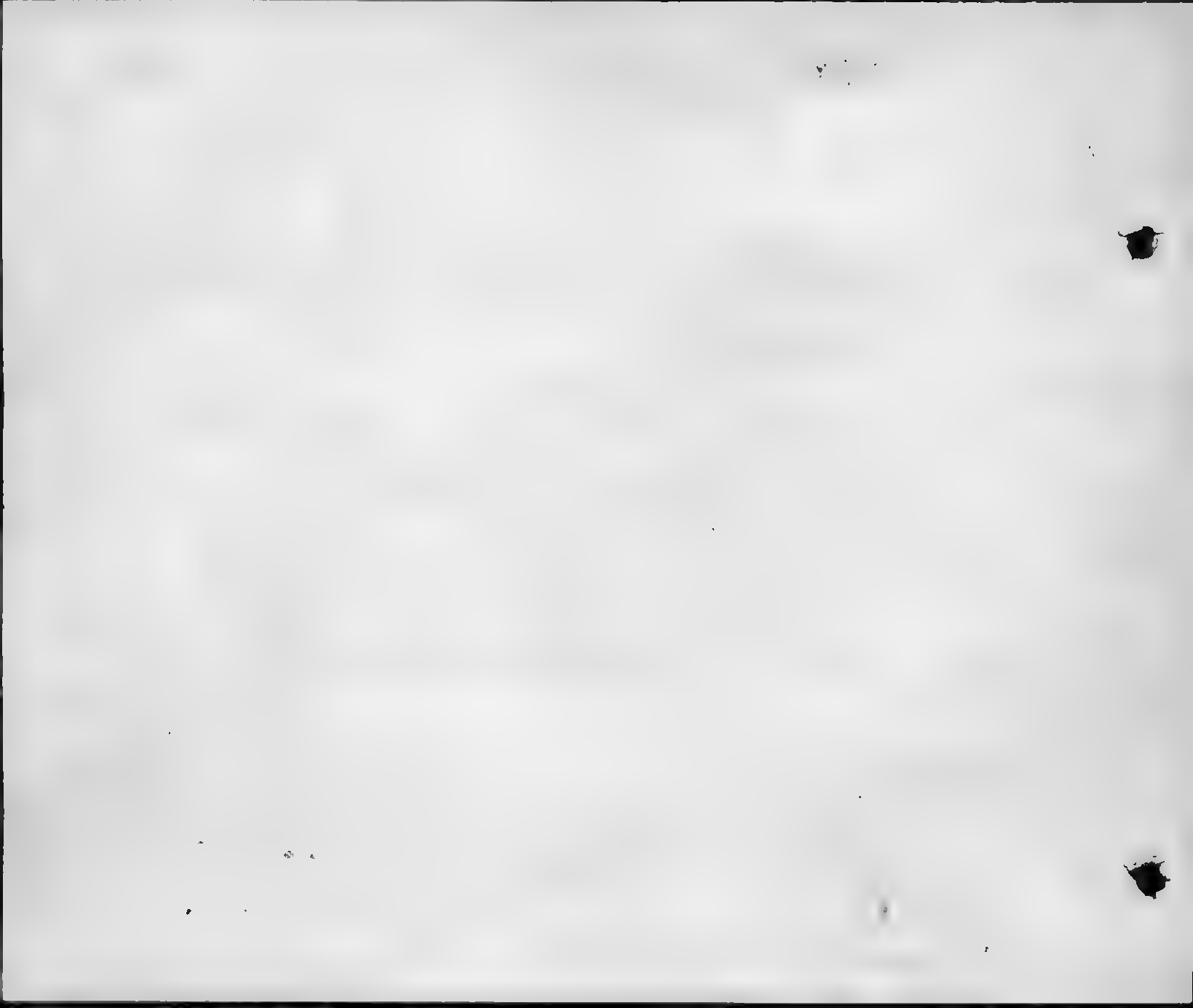
10477

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u><br>c. LENGTH OF STAY in 1b <u>10 hours</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp</u>                   |   | 2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12, Maryland</u><br>d. STREET ADDRESS <u>1307 Elson Court</u> |   |
| 3. NAME OF DECEASED (Type or print) <u>FRANK C WEEMS, SR.</u>  |   | 4. DATE OF DEATH <u>September 3 1961</u>  |   |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>11-1-78</u>                                   |
| 9. AGE (In years last birthday) <u>82 yrs.</u>   |   | 10. IF UNDER 1 YEAR: Months <u>82</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Memorandum</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Md. B.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. B.</u>   |   |
| 13. FATHER'S NAME <u>Theophilus Weems</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Margaret Betty</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |   | 16. SOCIAL SECURITY NO. <u>Hospital Record</u>  |   |
| 17. INFORMANT <u>Hospital Record</u>   |   | Address <u>1307 Elson Court</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>42</u> DUE TO <u>CORONARY OCCLUSION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerotic Vasc Disease</u><br>DUE TO (c) <u>unknown</u> |   | INTERVAL BETWEEN ONSET AND DEATH <u>1-Day</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m. <u>0</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                              |
| 21. I certify that (I) (this hospital) attended the deceased from <u>February 1958</u> to <u>Sept 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 3, 1961</u> , and that death occurred at <u>9:01 PM</u> , from the causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE <u>Robert A. Hare</u> M.D.  |   | 22b. DATE <u>9/3/61</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>  |   | 22d. ADDRESS <u>7600 Carroll Ave, Tpk. Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>  | 23b. DATE THEREOF <u>9/7/61</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>   | 23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hunsicker</u>   |   | 25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>  |   |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunsicker</u>  |   |   |   |

MEDICAL CERTIFICATION

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

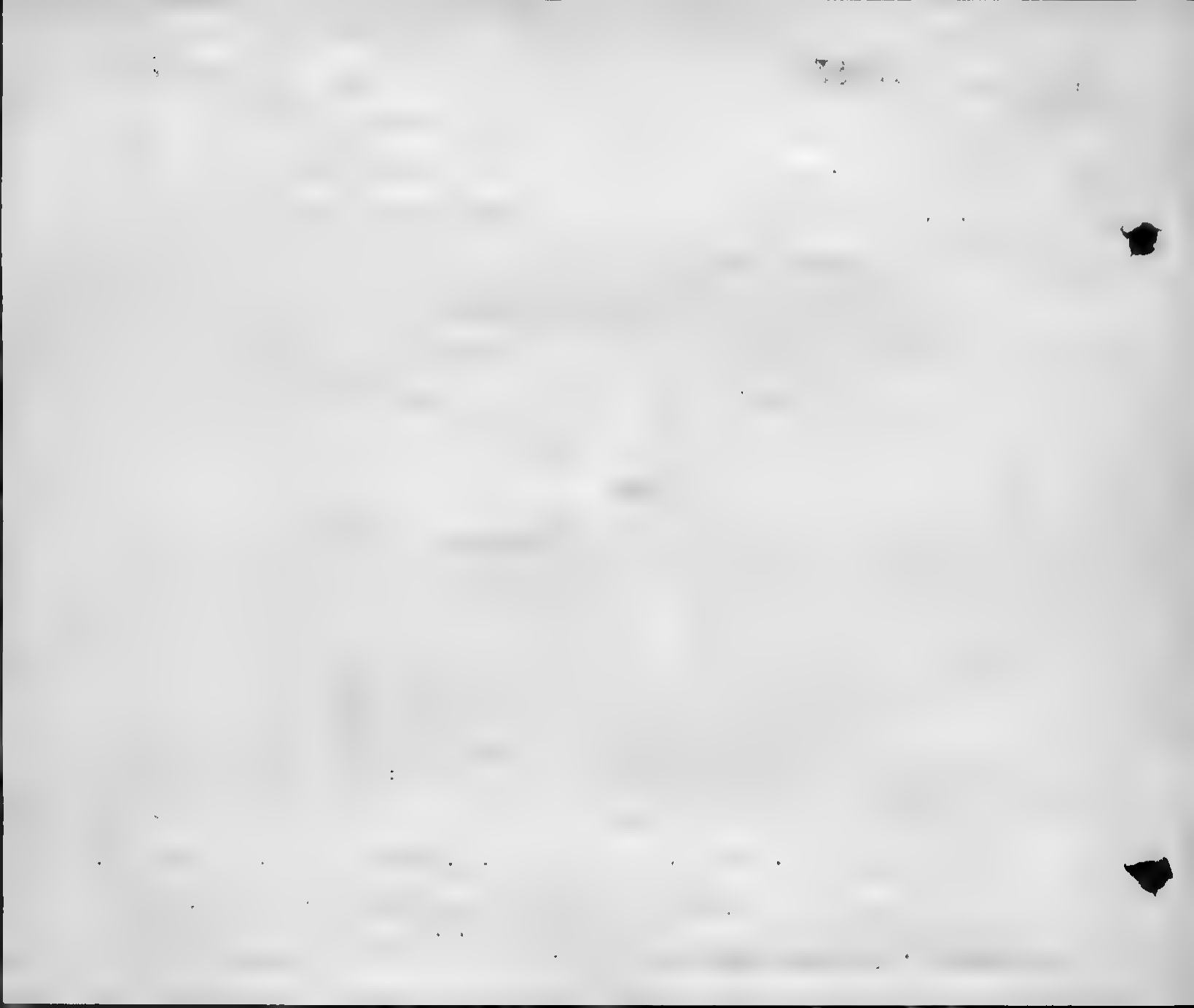


TO EXHIBIT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |   |  |   |  |  |  |   |  |
|--|--|-------------------------------|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |   |  |   |  |  |  |   |  |
| 10485  |  |                               |  |   |  | 10478   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  |                               |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if first full on; Residence before admission)<br>a. STATE<br>Florida<br>b. COUNTY<br>Jacksonville<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Jacksonville<br>d. STREET ADDRESS<br>6511 Burgundy Rd. South |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |  |                               |  |   |  | c. LENGTH OF STAY IN 1b<br>50 days  |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U. S. Naval Hospital   |  |                               |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Birder Franklin Welch  |  |                               |  |   |  | 4. DATE OF DEATH<br>September 6 19 61   |  |  |  |   |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>Caucasian |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>12-17-10  |  | 9. AGE (In years last birthday)<br>50 yrs.                       |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Louisiana |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA           |  |
| 13. FATHER'S NAME<br>Tilden Richard Franklin   |  |                               |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Ella Irene Hopkins  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br>No   |  |                               |  |   |  | 16. SOCIAL SECURITY NO.<br>(H) Denver Evans Welch Same as #2 above  |  |  |  |   |  |
| 17. INFORMANT<br>Address   |  |                               |  |   |  | 18. INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                               |  |   |  |   |  |  |  |   |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                               |  |   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cachectic</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>hepato sarcoma, uterus</i><br>DUE TO<br>(b)<br>(c)                   |  |                               |  |   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                               |  |   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  |   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |                               |  |   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |                               |  |   |  |   |  |  |  |   |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |                               |  |   |  |   |  |  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                               |  |   |  |   |  |  |  |   |  |
| 20f. (City or town) (County) (State)   |  |                               |  |   |  |   |  |  |  |   |  |
| 21. I certify that (H) (this hospital) attended the deceased from July 18, 19 61 to September 6, 19 61 that (H) (we) last saw the deceased alive on September 6 19 61, and that death occurred at 10:15 AM from the causes and on the date stated above. |  |                               |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><i>Robert H. Perkins</i> M.D.  |  |                               |  |   |  |   |  |  |  |   |  |
| 22b. DATE<br>6 September 1961  |  |                               |  |   |  |   |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>ROBERT H. PERKINS, LT MC USN   |  |                               |  |   |  |   |  |  |  |   |  |
| 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.  |  |                               |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                               |  |   |  |   |  |  |  |   |  |
| 23b. DATE THEREOF<br>7 Sept. 1961  |  |                               |  |   |  |   |  |  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Riverside Memorial Park  |  |                               |  |   |  |   |  |  |  |   |  |
| 23d. LOCATION (City, town or county) (State)<br>Jacksonville, Florida  |  |                               |  |   |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>Robert A. Humphrey</i>  |  |                               |  |   |  |   |  |  |  |   |  |
| 25a. REC'D BY REGISTRAR<br>DATE SEP 11 '61   |  |                               |  |   |  |   |  |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kline</i>   |  |                               |  |   |  |   |  |  |  |   |  |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

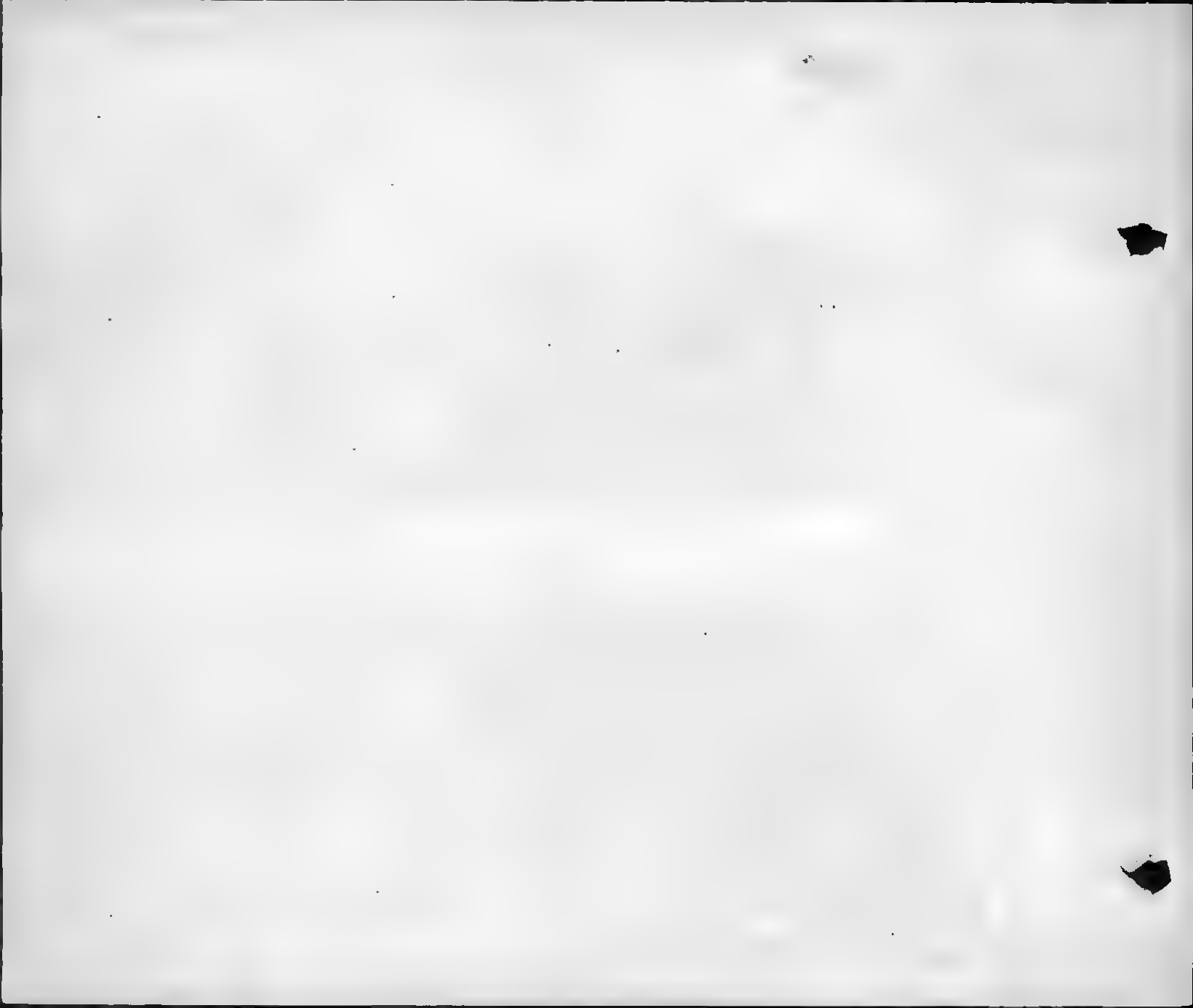
10479

10486

**CERTIFICATE OF DEATH**

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ednor</i>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belmont Nursing Home</i>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <i>MARY K. WELLS</i>   |                               | 4. DATE OF DEATH <i>Sept. 26, 1961</i>   |   |
| 5. SEX <i>Female</i>   | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>February 10, 1876</i> |
| 9. AGE (In years last birthday) <i>85</i> yrs  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk - retired</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>Department Store</i>  |   |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>   |   |
| 13. FATHER'S NAME <i>Henry Deaham</i>  |                               | 14. MOTHER'S MAIDEN NAME <i>Amelia Kirkland</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>   |                               | 16. SOCIAL SECURITY NO. <i>215-10-8954</i>   |   |
| 17. INFORMANT <i>Mrs. Charles F. Fisher (same as #2)</i>   |                               | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                               |  |   |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Thrombosis (myocardial)</i> 6 weeks and 4 days.   |                               |  |   |
| (b) <i>Generalized Atherosclerosis</i> years -   |                               |  |   |
| (c)  |                               |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>① Chronic Pyelonephritis</i> <i>② Parkinsonism</i>  |                               |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>Sept. 23</i> to <i>Sept. 26</i> , 19 <i>61</i> , that (I) <del>(the hospital)</del> last saw the deceased alive on <i>Sept. 23</i> , 19 <i>61</i> , and that death occurred at <i>8:45</i> AM, from the causes and on the date stated above |                               |  |   |
| 22a. SIGNATURE <i>J. Blaine Fitzgerald</i>   |                               | 22b. DATE SIGNED <i>9/26/61</i>  |   |
| 22c. PHYSICIAN'S NAME (Type) <i>J. BLAINE FITZGERALD</i>   |                               | 22d. ADDRESS <i>8218 Wisconsin Avenue Bethesda</i>   |   |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>   |                               | 23b. DATE THEREOF <i>Sept. 28, 1961</i>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>  |                               | 23d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Kraus</i>  |                               | 25a. RECORDED BY REGISTRAR <i>SEP 28 '61</i>   |   |
| ADDRESS <i>24 Carroll St NW DC</i>   |                               | 25b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>  |   |

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





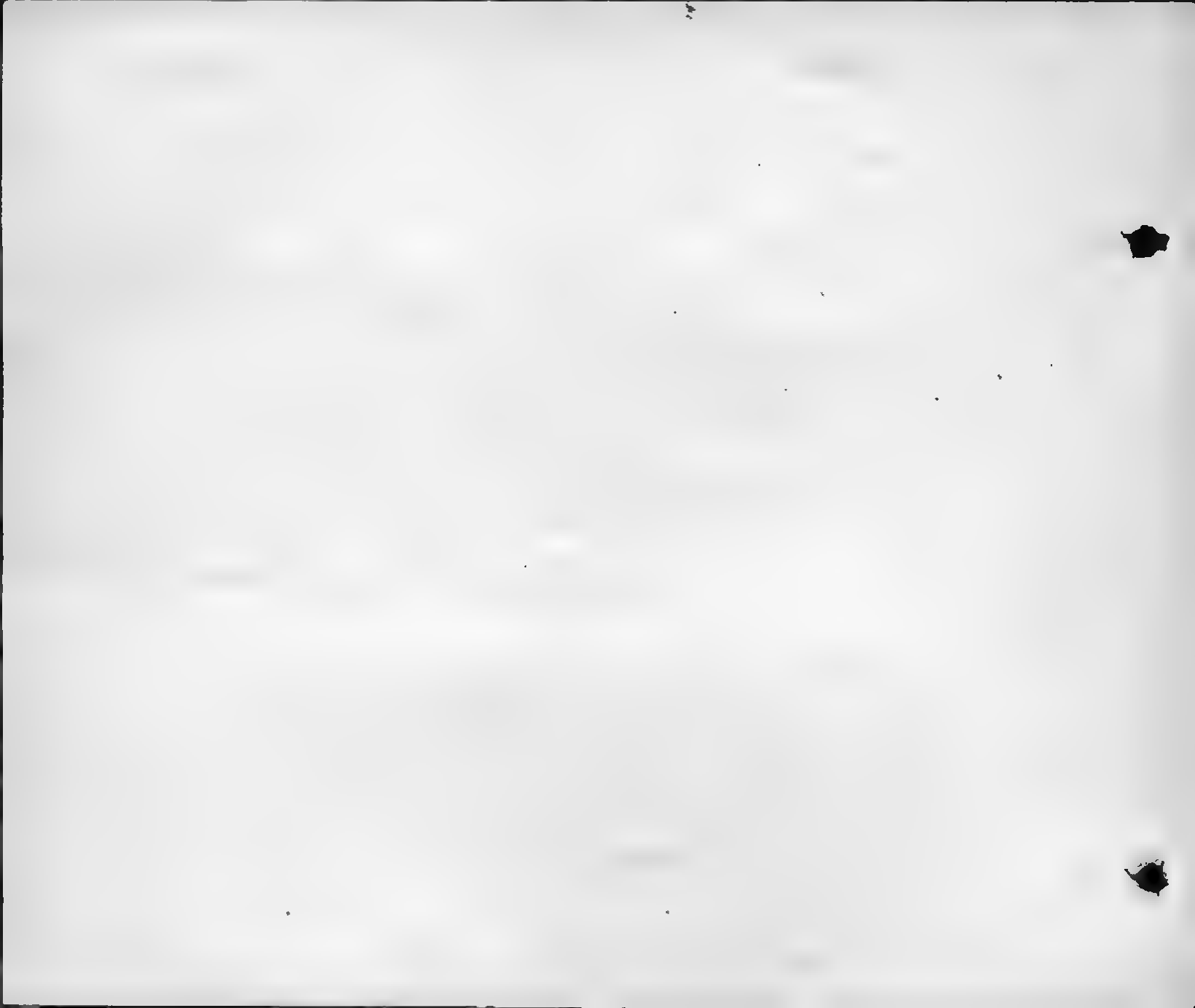
may be obtained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10487  
MONTGOMERY  
TAKOMA PARK  
WASH. SEN. HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10481  
MONTGOMERY  
SILVER SPRING  
3901 ILFORD ROAD

|  |   |  |  |  |   |   |  |
|--|---|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write name and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>1</b>   |   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write name and give nearest town) <b>SILVER SPRING</b> |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BURT</b> Middle <b>HORTON</b> Last <b>WESTON</b>   |   |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>15</b> Year <b>1961</b>  |   |   |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2-12-81</b>  | 9. AGE (In years last birthday) <b>80</b> yrs  | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Shipman</b>   |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Waterman, N.Y.</b>                        |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |  |
| 13. FATHER'S NAME <b>William M. Weston</b>   |   |  | 14. MOTHER'S MAIDEN NAME <b>Emma Cherry</b>                                    |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |   | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |  | 17. INFORMANT <b>Hospital records</b> Address  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SHOCK -</b><br><b>541.0</b> DUE TO <b>BRONCHOPNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO <b>POST-OP GASTRECTOMY FOR BLEEDING ULCER - DUODENUM</b><br>(c) |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>11 days</b>                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Month <b>19</b> Day <b>19</b> Year <b>19</b><br>Hour <b>0</b> a. m. <b>0</b> p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)  | (County)   | (State)   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>SEPT 4</b> , 19 <b>61</b> , to <b>SEPT 15</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>SEPT 15</b> , 19 <b>61</b> , and that death occurred at <b>8:00</b> M, from the causes and on the date stated above  |   |  |  |  |   |   |  |
| 22a. SIGNATURE<br><b>Frederick B. Brandt, M.D.</b>   |   | 22b. DATE<br><b>Sept 15 '61</b>  | 22c. PHYSICIAN'S NAME (Type)<br><b>FREDERICK B. BRANDT, M.D.</b>               |  |   |   |  |
| 22d. ADDRESS<br><b>1726 EYE ST. N.W. D.C.</b>  |   | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)   | 23b. DATE THEREOF<br><b>9/18/61</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Pr. Geo. Co., Maryland</b> |  |   |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. S. N. Smith</b>  |   | 24a. ADDRESS<br><b>3901 Ilford Rd. Silver Spring, Md.</b>  | 25a. REC'D BY REGISTRAR<br><b>SEP 18 '61</b>                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>  |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND AND DISTRICT OF COLUMBIA

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10488

## CERTIFICATE OF DEATH

10482

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>2 weeks</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federsburg</u><br>d. STREET ADDRESS <u>Academy Avenue</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Maggie Carrie Wheatley</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>9</u> Day <u>17</u> Year <u>1961</u>  |  |
| <b>5. SEX</b> <u>F</u>   |  | <b>6. COLOR OR RACE</b> <u>W</u>  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug 31 1879</u>   |  | <b>9. AGE</b> (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Dorchester Co. Md.</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>   |  |
| <b>13. FATHER'S NAME</b> <u>Archie Reagan</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Georgeanna (maiden name unknown)</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>   |  |
| <b>17. INFORMANT</b> <u>Davey Wheatley</u>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u><br>DUE TO (c) <u>Arteriosclerosis Generalized</u> |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | <b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>   |  | <b>20b. TIME OF INJURY</b> Month, Day, Year: <u>19</u>  |  |
| <b>20c. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> (County) <u>  </u> (State) <u>  </u>  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>20 Aug 1961</u> to <u>17 Sep 1961</u> that (I) (we) last saw the deceased alive on <u>15 Sep 1961</u>, and that death occurred <u>10 p.m.</u> from the causes and on the date stated above.</b>  |  |   |  |
| <b>22a. SIGNATURE</b> <u>Thomas P. Fogarty</u> M.D.  |  | <b>22b. DATE SIGNED</b> <u>10/10/61</u>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Thomas P. Fogarty</u>   |  | <b>22d. ADDRESS</b> <u>1011 Univ. Blvd. E. Silver Spring Md.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  | <b>23b. DATE THEREOF</b> <u>Sept. 20, 1961</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>East New Market Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) <u>East New Market, Maryland</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James T. Ryan</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>SEP 20 1961</u>   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Haines</u>  |  | <b>25c. ADDRESS</b> <u>Washington</u>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

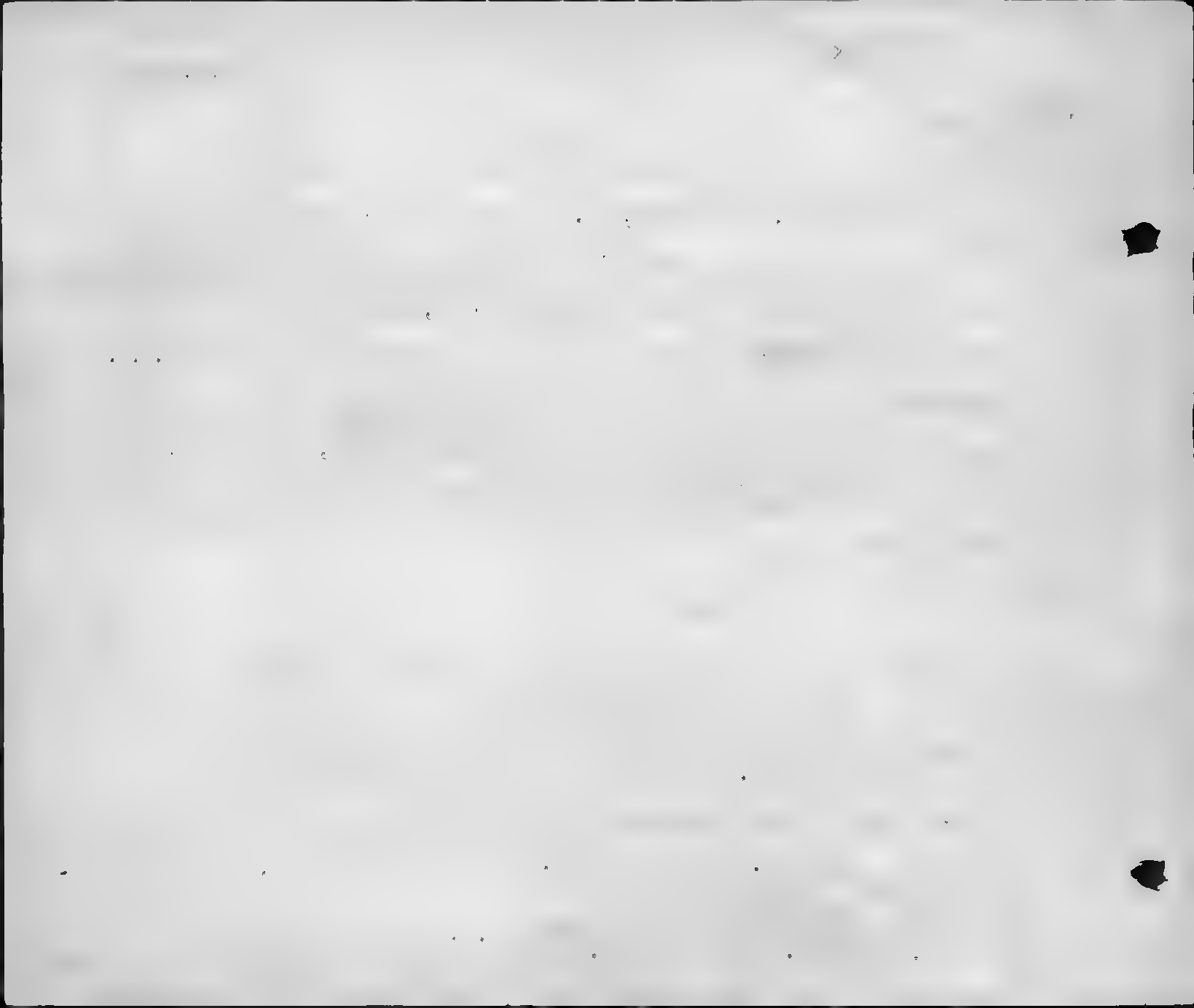
## CERTIFICATE OF DEATH

10489

10483

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Montgomery<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda<br>c. LENGTH OF STAY IN b.<br>16 days<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Virginia<br>b. COUNTY<br>Lynnhaven<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>188 Lynnhaven Drive<br>d. STREET ADDRESS<br>188 Lynnhaven Drive |  |  |  |
| <b>3. NAME OF</b><br>(Type or print)<br>Robert Samuel<br><b>5. SEX</b><br>Male<br><b>6. COLOR OR RACE</b><br>White   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b><br>August 10, 1909 |  | <b>9. AGE</b> (In years last birthday)<br>52<br><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, e.g., Secretary & Treasurer<br><b>11. BIRTHPLACE</b> (County & State, or foreign country)<br>Virginia<br><b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.               |  |  |  |
| <b>13. FATHER'S NAME</b><br>Samuel White<br><b>14. MOTHER'S MAIDEN NAME</b><br>Gertrude Cooper   |  |  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>No<br><b>16. SOCIAL SECURITY NO.</b><br>Not available<br><b>17. INFORMANT</b> The Medical Record  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Septicemia, gram negative<br>DUE TO (b) Acute myelogenous leukemia<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br>48 hours<br>8 weeks  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. 19<br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |  |  |  | <b>19. WAS AUTOPSY PERFORMED</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from Sept. 7, 1961 to Sept. 23, 1961, that (I) (we) last saw the deceased alive on Sept. 23, 1961, and that death occurred at 10:15 AM, from the causes and on the date stated above.</b>  |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br>Thorne S. Winter, III M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type)   |  |  |  | <b>22b. DATE SIGNED</b><br>9-23-61<br><b>22d. ADDRESS</b><br>The Clinical Center, National Institutes of Health, Bethesda 14, Md.   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>removal  |  | <b>23b. DATE THEREOF</b><br>9/23/61  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>Norfolk, Virginia  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br>The S.H. Hines Co., 2901 14th St. N.W.  |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE SEP 26 '61<br><b>25b. REGISTRAR'S SIGNATURE</b><br>Arthur S. Hines   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**10490 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10484**

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>c. LENGTH OF STAY IN 1b <u>1 day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Ordnance</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>ind</u><br>f. COUNTY <u>montg</u><br>g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>h. STREET ADDRESS <u>110711 E Nolcrest Dr</u><br>i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Floyd Willis J</u><br>First Middle Last<br><b>4. DATE OF DEATH</b><br><u>Sept 25 1961</u><br>Month Day Year  |  | <b>5. SEX</b><br><u>male</u><br><b>6. COLOR OR RACE</b><br><u>white</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>11-7-07</u><br>Year Month Day   |  |
| <b>9. AGE</b> (In years, if UNDER 1 YEAR, If UNDER 24 HRS. last birthday) <u>53</u> yrs. Months Days Hours Min  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrical Eng. Laboratory</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>Miss</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  |
| <b>13. FATHER'S NAME</b><br><u>Floyd Willis</u><br><b>14. MOTHER'S MAIDEN NAME</b><br><u>Susie Mooror</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>442-03-4068</u><br><b>17. INFORMANT</b> <u>Naval Ordnance Record</u> Address   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (c) _____<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| <b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>20a. EXTERNAL CAUSE (PRIMARY or CONTRIBUTING CAUSE OF DEATH) _____<br>20b. TIME OF INJURY Month, Day, Year _____<br>20c. INJURY OCCURRED _____<br>20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____<br>20e. (City or town) _____ (County) _____ (State) _____  |  |   |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b><br>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-25-61</u><br>Address (Street, city, town, or county) _____ |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Broschaw</u> M.D.<br><b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Broschaw</u><br><b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u><br><b>22b. DATE THEREOF</b> <u>9/27/61</u><br><b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u><br><b>22d. LOCATION</b> (City, town, or country) (State) <u>Montgomery County, Maryland</u><br><b>23. FUNERAL DIRECTOR</b> <u>Raymond A. Ziskor</u> ADDRESS <u>8434 Georgia Avenue</u><br><u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Maryland</u><br><b>24a. REC'D BY REGISTRAR</b> <u>SEP 28 '61</u><br><b>24b. REGISTRAR'S SIGNATURE</b> <u>William S. Thomas</u>                                   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10491 CERTIFICATE OF DEATH 10485

|  |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>                     |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>E. Hyattsville,</u><br>d. STREET ADDRESS <u>1434 University Blvd.,</u> |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Baby Boy</u><br>First Middle Last<br>4. DATE OF DEATH <u>9</u> <u>29</u> <u>1961</u><br>Month Day Year  |  | 5. SEX <u>Male</u><br>6. COLOR OR RACE <u>White</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>9/29/61</u><br>9. AGE (In years last birthday) <u>9</u> IF UNDER 1 YEAR: Months <u>2</u> Days <u>8</u> IF UNDER 24 HRS. <u>8</u>   |  |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE County & State, or foreign country  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 13. FATHER'S NAME <u>John William Wilson</u>   |  | 14. MOTHER'S MAIDEN NAME <u>ILENE Elizabeth Shatler</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or date of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT <u>father</u> Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u><br>154.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Suspected pulmonary pathology</u><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u><br><u>2 hrs</u>   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |  | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Large patent foramen ovale and large patent ductus arteriosus</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20e. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 29, 1961</u> to <u>Sept. 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 29, 1961</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.   |  | 22a. SIGNATURE <u>Ernest E. Harmon, M.D.</u> M.D.<br>22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon, M.D.</u>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u> |  | 22b. DATE SIGNED  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>Oct. 3, 1961</u>  |  |
| 23b. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>   |  | 23c. LOCATION (City, town or county) (State) <u>Rockville Md.</u>   |  | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>   |  | 25a. REC'D BY REGISTRAR <u>Oct 4 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:**

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should.

Doct. of Health or Cor. Dr.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10492

## CERTIFICATE OF DEATH

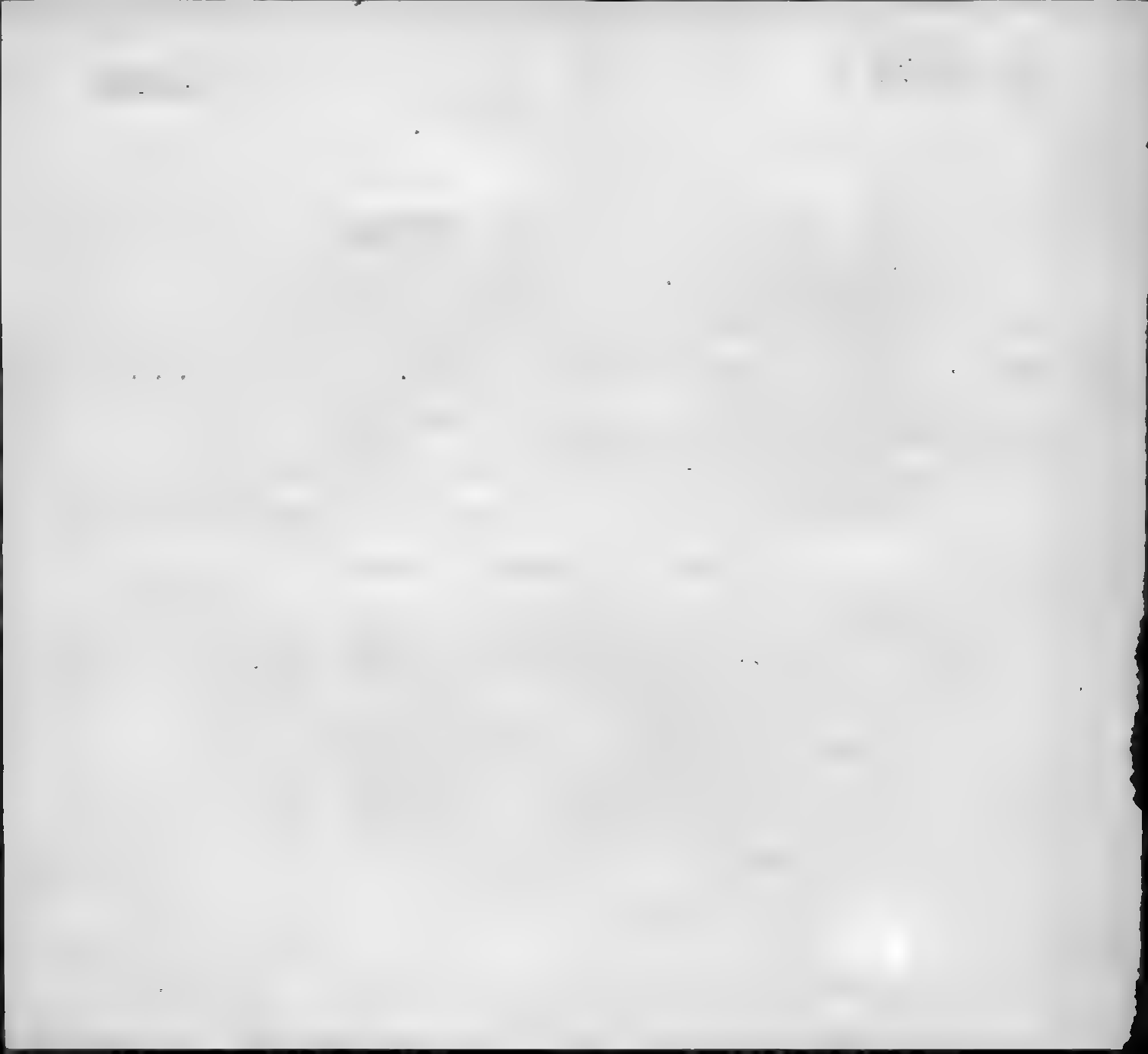
10486

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission)<br>a. STATE <u>D. C.</u><br>b. COUNTY <u>Washington</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Buburban</u>   |  | d. STREET ADDRESS<br><u>4215 Ellicott St</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>William</u> <u>U.</u> <u>Wilson</u>   |  | <b>4. DATE OF DEATH</b><br><u>September 28,</u> <u>1961</u>  |  |
| <b>5. SEX</b><br><u>Male</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>2/28/14</u>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Checker</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Penn.</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>William V. Wilson</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Jane Mather</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>no</u>   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>178-05-1291</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter on one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u><br>DUE TO <u>Coronary sclerosis, severe</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO <u>Posterior wall Myocardial Inf. July 17 1961 &amp; Anterior Wall Infarction 7.30.61</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Posterior wall Myocardial Inf. July 17 1961 &amp; Anterior Wall Infarction 7.30.61</u> |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>9:14</u> p.m. <u>54</u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                          |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><u>4740 Chevy Chase Dr</u>   |  | <b>20f. (City or town)</b> (County) (State)<br><u>Washington</u> <u>D.C.</u>   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9.14.1961</u> <b>to</b> <u>9.28.1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>9.27.1961</u> <b>and that death occurred at</b> <u>8:55 A.M.</u> <b>from the causes and on the date stated above.</b>   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Stuart Clapp</u>  |  | <b>22b. DATE SIGNED</b><br><u>9.28.61</u>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Stuart Clapp</u>  |  | <b>22d. ADDRESS</b><br><u>4740 Chevy Chase Dr</u>  |  |
| <b>23a. BURIAL, CREMATION, or REMOVAL</b> (Specify)<br><u>Burial</u>  |  | <b>23b. DATE</b><br><u>9.30.61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>East Lincoln Ave</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Bladensburg</u> <u>MD</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Chevy Chase Funeral Home</u>  |  | <b>25. REC'D BY REGISTRAR</b><br><u>Arthur S. H...</u>   |  |

DR. BROCHART NOTIFIED

MEDICAL CERTIFICATION

within 72 hours after death, burial, cremation, or removal, and in any case within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

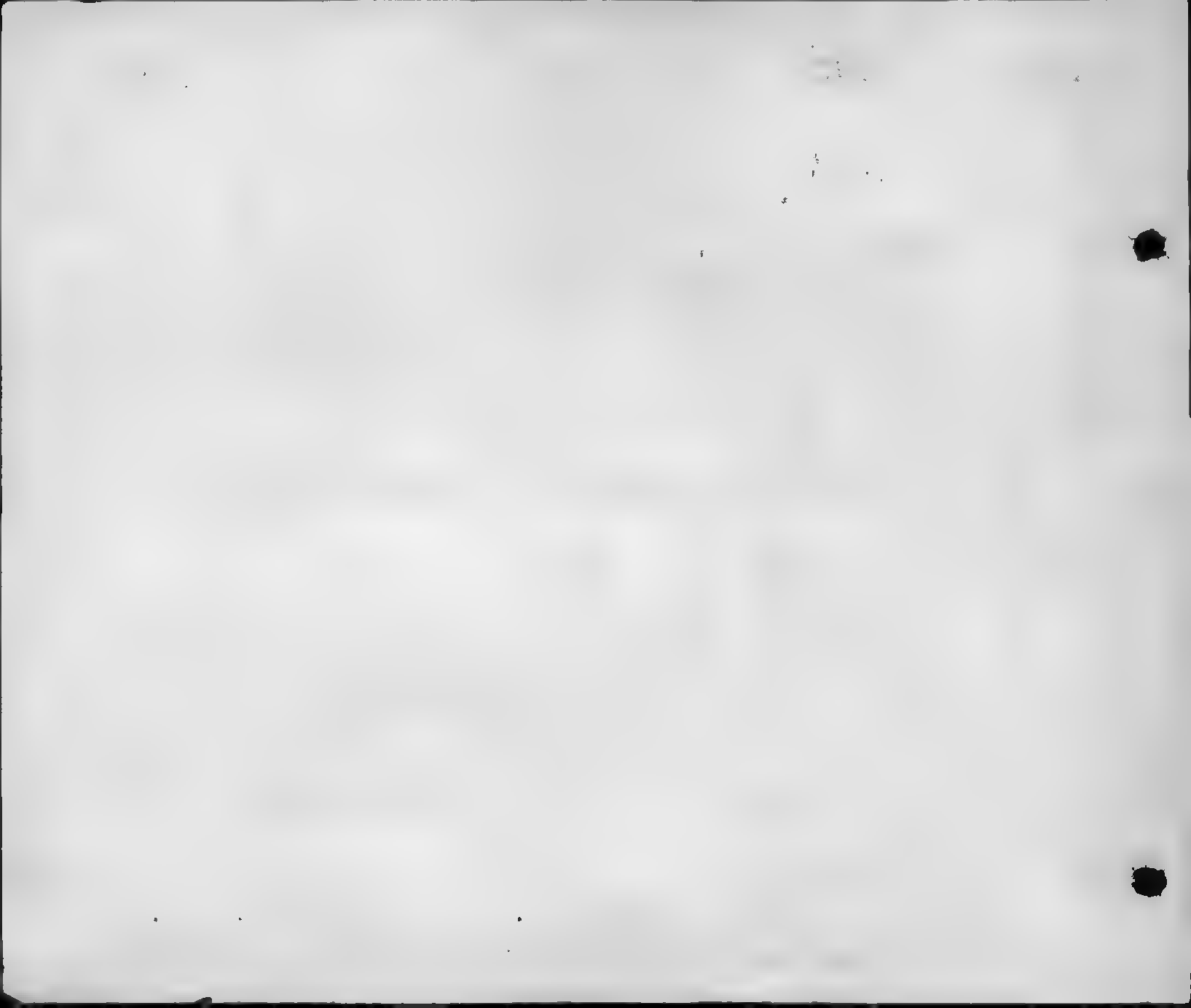
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10493

10487

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>3 hrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Washington Sanitarium + Hospital</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived if institution; residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>1</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u><br>d. STREET ADDRESS <u>3907 Oglethorpe St</u> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Bertha Lucille Woodling</u>  |  | <b>4. DATE OF DEATH</b><br>Last <u>9</u> Month <u>3</u> Day <u>19</u> Year <u>61</u>  |  |
| <b>5. SEX</b><br><u>F</u>   |  | <b>6. COLOR OR RACE</b><br><u>W</u>   |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>1-2-79</u>  |  | <b>9. AGE</b> (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  |
| <b>11. ETHNICITY</b> (County & State or foreign country) <u>PA</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>Am.</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>Benjamin F Evans</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>MARY JAMES</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)   |  | <b>16. SOCIAL SECURITY NO.</b>  |  |
| <b>17. INFORMANT</b><br><u>Hospital Record</u>  |  | <b>Address</b>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u><br><u>420.0</u> DUE TO <u>acute myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>arterio-sclerotic disease</u><br>(c) <u>Heart Disease</u> |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>3 days</u><br><u>3 days</u><br><u>8 years</u>   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)</b>   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 1954</u> <b>to</b> <u>3 Sept., 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3 Sept., 1961</u> , <b>and that death occurred at</b> <u>10:30 A.M.</u> , <b>from the causes and on the date stated above</b>   |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Russell B. Arnold</u>   |  | <b>22b. DATE SIGNED</b><br><u>9/3/61</u>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Russell B. Arnold M.D.</u>  |  | <b>22d. ADDRESS</b><br><u>8301 Colesville Road, Silver Spring, MD</u>   |  |
| <b>23a. BURIAL, CREMATION REMOVAL (Specify)</b><br><u>Removal</u>   |  | <b>23b. DATE THEREOF</b><br><u>9/5/61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Dunmore Cem.</u>  |  | <b>23d. LOCATION (City, town or county)</b><br><u>SCRANTON, PENN.</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>S.H. Hines Co</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 7 '61</u>  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Hines</u>   |  |   |  |



10494

## CERTIFICATE OF DEATH

Reg. Dist. No. 10488

|   |                               |  |                                   |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution—residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>             |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Silver Spring</u>  |                               | c. LENGTH OF STAY IN 1b <u>6 days</u>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarscroft Sanitarium and Hospital</u>   |                               | d. STREET ADDRESS <u>125500 Oak Drive</u>  |                                   |
| 3. NAME OF DECEASED (Type or print) First <u>Lenora</u> Middle <u>Young</u> Last <u>Young</u>   |                               | 4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1961</u>   |                                   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-13-1885</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs.  |                               | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                   |
| 13. FATHER'S NAME <u>William Franklin Buval</u>   |                               | 14. MOTHER'S MARDEN NAME <u>Harriett Purdum</u>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |                                   |
| 17. INFORMANT <u>Cedarscroft records, and relatives, Mrs. James Hawkins, Gaithersburg</u>   |                               | Address <u>  </u>  |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Cachexia</u><br>DUE TO <u>Generalized Carcinomatosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u><br>DUE TO (c) <u>  </u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>  </u>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |                                   |
| 20c. TIME OF INJURY Month, Day, Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |                               | 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>   |                                   |
| 21. I certify that I attended the deceased from <u>Sept 23, 1961</u> , to <u>Sept. 29, 1961</u> , that I last saw the deceased alive on <u>Sept 28, 1961</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.  |                               |  |                                   |
| ACTUAL SIGNATURE <u>Henry E. Andren</u> M.D.  |                               | ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Pk.</u> DATE SIGNED <u>9/29/61</u>   |                                   |
| PHYSICIAN'S NAME (Type) <u>HENRY E. ANDREN, M.D.</u>  |                               | <u>7600 CARROLL AVE. TAK. PK.</u>  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>Oct. 2, 1961</u>  |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>  |                               | 22d. LOCATION (City, town, or county) <u>Damascus, Md.</u> (State) <u>  </u>   |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Moleworth</u> ADDRESS <u>Damascus, Md.</u>  |                               | 24a. REC'D BY REGISTRAR <u>  </u> DATE <u>OCT 4 '61</u>  |                                   |
| 24b. REGISTRAR'S SIGNATURE <u>  </u>  |                               |  |                                   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15284

1953

M

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is filled out with handwritten text.

**DECEASED**  
Name: John Doe  
Age: 45  
Sex: Male  
Race: White  
Date of Birth: 10/15/1908  
Date of Death: 11/10/1953  
Time of Death: 10:30 AM  
Place of Death: Home  
Cause of Death: Heart Disease  
Signature: [Signature]  
Registrar: [Signature]  
Physician: [Signature]  
Municipal Health Officer: [Signature]  
County Health Officer: [Signature]  
State Health Officer: [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

(M)

(I)

MEDICAL CERTIFICATION

| MAYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |  |  |  |  |  |  |  |  |
| 10495 CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |  |  |  |
| Items 1c & 21 Film G295 9/21/61 ink  |  |  |   |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY in b <b>300 / 299 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>  |  |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, last date of admission)<br>a. STATE <b>Virginia</b><br>b. COUNTY <b>Arlington</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arlington</b><br>d. STREET ADDRESS <b>1505 North Quinn Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Karolis Arthur Zalkauskas</b>  |  |  | 4. DATE OF DEATH<br><b>September 16, 19 61</b>  |  |  | 5. SEX<br><b>Male</b>  |  |  | 6. COLOR OR RACE<br><b>White</b>   |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH<br><b>May 29, 1892</b>   |  |  | 9. AGE (In years last birthday) <b>69</b> yrs.   |  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Judge</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Law</b>   |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Lithuania</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |  |  |
| 13. FATHER'S NAME<br><b>Vincas Zalkauskas</b>  |  |  |   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ada Blankenfield</b>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)<br><b>NO</b>  |  |  |   |  |  | 16. SOCIAL SECURITY NO.<br><b>Unascertainable</b>  |  |  |  |  |  |
| 17. INFORMANT<br><b>The Medical Records</b>  |  |  |   |  |  | Address<br><b>The Clinical Center, Bethesda 14, Maryland</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Medullary Compression</b><br>DUE TO (c) <b>Meningioma, left Parietal Lobe</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Nephrosclerosis of kidneys, moderate, Pulmonary emphysema, congestive heart failure</b><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |  |  |   |  |  |  |  |  |  |  |  |
| 20a. TIME OF INJURY<br>Hour a.m. p.m. <b>19</b>  |  |  | 20b. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  | 20d. (City or town) (County) (State)                                     |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>November 20, 1960</b> to <b>September 16, 1961</b> that (I) (we) last saw the deceased alive on <b>September 16, 1961</b> and that death occurred at <b>2:15 PM</b> from the causes and on the date stated above.   |  |  |   |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Robert L. Fisher</b><br>M.D.  |  |  |   |  |  | 22b. DATE SIGNED<br><b>9-17-61</b>   |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert L. Fisher M.D.</b>   |  |  |   |  |  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE THEREOF<br><b>9-19-1961</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>   |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Washington, D. C.</b> |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Lawrence Sons, Inc. 1750 Pa Ave NW</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 19 '61</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles L. Hume</b>                     |  |  |

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